DOCUMENT RESUME

ED 107 537 SO 007 920

TITLE	Institute on Human Values in Medicine. Proceedings of the First Session, April 12-14, 1971.
INSTITUTION	Society for Health and Human Values, Philadelphia, Pa.
SPONS AGENCY	National Endowment for the Humanities (NFAH), Washington, D.C.
PUB DATE	72
NOTE	132p.; For related documents, see SO 007 921, 922, 934, and 935; Not available in hard copy, Out of Print
EDRS PRICE	MF-$0.76 HC Not Available from EDRS. PLUS POSTAGE
DESCRIPTORS	Ethical Values; *Health; Higher Education; Humanism; Humanities; *Humanization; *Medical Education; *Medicine; Philosophy; *Values

ABSTRACT

The document relates the proceedings of the Institute on Human Values in Medicine, which explored issues involving human values (humanities) and medicine. The purpose of the first conference is to investigate some of the questions involving this relationship and to see if there is a need for better interpolation of the knowledge of the humanities within the framework of education in all of the health professions. The keynote presentation, entitled "The New Healer," examines the role and problems of physician and client, who are currently at odds on the definition of disease and health, as well as the expectations of what a health care system can or should produce. "Psychiatry and literature," the focus of the next presentation, suggests that health professionals can gain insight into the human condition by looking in-depth at human beings in a careful study of literature. The third presentation "Philosophy and Medicine," looks at some philosophical concerns which are helpful to the medical world. The document concludes with a summary of various group discussions concerned with the teaching of humanities in medical schools. The concluding address offers selective comments on previous discussions. The second and third proceedings are described in SO 007 921 and SO 007 922. (Author/JR)

Institute on Human Values in Medicine

PROCEEDINGS OF THE FIRST SESSION

Society for Health and Human Values

Institute on Human Values in Medicine

PROCEEDINGS OF THE FIRST SESSION

Arden House, Harriman, New York
April 12-14, 1971

Society for Health and Human Values

Chairman of the Institute:
Edmund D. Pellegrino, M.D.
Vice President for Health Sciences
Director of the Center
State University of New York
Stony Brook, New York

Project Director:
Lorraine L.Hunt
1506 Bolton Street
Baltimore, Maryland

Sponsor and Administrator:
Society for Health and Human Values
825 Witherspoon Building
Philadelphia, Pennsylvania
Ronald W. McNeur, PhD., Executive Director

Funded by the National Endowment for the Humanities — Grant No. EO-194-70-4163

TABLE OF CONTENTS

Advisory Committee
of the
Institute on Human Values in Medicine

Edmund D. Pellegrino, M.D., Chairman
Vice President for the Health Sciences
Director of the Center
State University of New York at Stony Brook

Samuel A. Banks, Ph.D.
Associate Professor of Medicine and Religion
Department of Community Health
University of Florida at Gainesville

Lorraine L. Hunt, Ph.D.
Project Director
Institute on Human Values in Medicine

E. A. Vastyan, B.D.
Associate Professor and Chairman
Department of Humanities
Milton S. Hershey Medical Center
College of Medicine
The Pennsylvania State University at Hershey

George A. Wolf, Jr., M.D.
Professor of Medicine
College of Medicine
University of Vermont, Burlington

Ronald W. McNeur, Ph.D.
Executive Director
Society for Health and Human Values

Consultants
to the
Institute Advisory Committee

Roger J. Bulger, M.D.
Executive Officer
Institute of Medicine
National Academy of Sciences

K. Danner Clouser, Ph.D.
Associate Professor of Humanities
Milton S. Hershey Medical Center
The Pennsylvania State University at Hershey

Sherman M. Mellinkoff, M.D.
Dean of the School of Medicine
University of California at Los Angeles

Richard C. Reynolds, M.D.
Chairman, Department of Community Health
College of Medicine
University of Florida at Gainesville

William A. Tisdale, M.D.
Professor and Chairman, Department of Medicine
College of Medicine
University of Vermont, Burlington

Bernard Towers, M.B., Ch.B.
Professor of Pediatrics and Anatomy
Center for the Health Sciences
University of California at Los Angeles

Ruel W. Tyson, Jr., B.D.
Assistant Professor of Religion
University of North Carolina at Chapel Hill

Richard M. Zaner, Ph.D.
Professor of Humanities and Professor of Philosophy
Chairman, Division of Social Sciences and Humanities
State University of New York at Stony Brook

Council
of the
Society for Health and Human Values
(1970-1971)

President	E. A. Vastyan, B.D., Associate Professor and Chairman, Department of Humanities The Milton S. Hershey Medical Center College of Medicine The Pennsylvania State University Hershey, Pennsylvania
President-elect	William F. Maloney, M.D., Dean of Medicine, Professor of Medicine Tufts University School of Medicine Boston, Massachusetts
Past President	Edmund D. Pellegrino, M.D., Vice President for the Health Sciences, Dean, School of Medicine State University of New York Stony Brook, New York
Class 1971	Samuel A. Banks, Ph.D., Assistant Professor of Medicine and Religion, Division of Community Health, Department of Medicine University of Florida Gainesville, Florida
Class 1971	Kenneth E. Spilman, S.T.M., Director Health and Human Values Task Force Metropolitan Philadelphia Philadelphia, Pennsylvania
Class 1972	C. H. William Ruhe, M.D., Director Division of Medical Education American Medical Association Chicago, Illinois
Class 1973	F. C. Redlich, M.D., Associate Provost, Dean, Yale University School of Medicine New Haven, Connecticut
Executive Director	Ronald W. McNeur, Ph.D., Society for Health and Human Values Philadelphia, Pennsylvania

BACKGROUND OF THE INSTITUTE

A plan for holding an Institute on Human Values in Medicine was first presented in November, 1969, in a proposal submitted to the National Endowment for the Humanities. The rationale of the proposal had been suggested by the findings of an earlier study funded by the Endowment, sponsored by the Association of American Medical Colleges, and conducted by Lorraine L. Hunt, Ph.D.

In the final report of the study, called "A Survey of the Current Status of Humanities Program in Selected Medical Schools," Dr. Hunt noted that nearly all of the administrators, teachers, clinicians, and researchers whom she interviewed in the course of the survey expressed a wish for a working conference at which humanists and medical educators might explore together new possibilities for the future course of humanities programs in medical settings.

Consensus on this point was so clear and extensive that convening such a conference seemed a logical next step, which the National Endowment for the Humanities made possible by awarding a grant to the Society for Health and Human Values early in 1970. The Society thus became the sponsor of An Institute on Human Values in Medicine, an "action-research" conference consisting of two three-day sessions. The first session was held at Arden House, Harriman, New York, April 12-14, 1971. The second session will occur April 26-28, 1972, at Williamsburg, Virginia.

These Proceedings report the efforts of the participants in the Institute's first session to pursue the goals described by Dr. Pellegrino in his welcoming remarks (pp. 3-9). Although the second session will have

different goals, its work will be based on the recommendations offered at the close of the discussions at Arden House. In general, the aim of the final session of the Institute will be to devise specific strategies by which humanists can make relevant contributions to medical education.

Lorraine L. Hunt, Ph.D.
Project Director and Editor

WELCOMING REMARKS

Edmund D. Pellegrino, M.D.

Chairman of the Institute
Past President of the Society for Health and Human Values

Vice President for the Health Sciences
Director of the Health Sciences Center
State University of New York
Stony Brook, New York

The Institute in which you have been kind enough to assist us is one of five projects now being carried on by the small group called the Society for Health and Human Values. The Society is small by choice at this time, and we hope it will remain so for awhile until we assess where we should go from here. If the interest in questions of human values that is now manifest in many medical schools and other schools of the university is as strong as it appears to be, we hope that the Society will grow, and perhaps have some impact on the directions that education will take in this country, and the decisions that will influence it.

The present Society evolved in April, 1969, out of an earlier and smaller group of humanists and medical educators who had formed the Committee on Health and Human Values in March, 1963, in pursuit of their common goal of promoting continuous dialogue between their respective disciplines.

Initially this Committee consisted of medical educators and theologians on medical school faculties and in other posts within higher education. This group had been meeting together informally during the four previous years to discuss problems in medical education, new questions in ethics, and difficulties in communication between medicine

and religion. Some of the Committee's members were then already engaged in experimental projects in medical education. The Danforth Foundation and the Russell Sage Foundation were among supporters of the work of this Committee, whose basic administrative needs were met by the United Ministries in Higher Education.

At the urging of many humanists and medical educators who shared the concerns of the Committee and wished to join in its efforts, in November, 1969, it changed its name and enlarged its structure, and recently it completed extension of its total membership to one hundred persons.

Our hope for this Institute is that it will bring some of us in medicine who are concerned with issues involving human values, into close discourse with those of you in the disciplines outside of medicine who have interest in, and perhaps a desire to help us with, the human problems that arise in medicine for the patient and the physician.

On almost every medical campus there is a subterranean current of interest in exploring potential contributions from the humanities to not only medicine, but all of the health professions. While the value of the humanities is acknowledged, there is uncertainty about the best means of bringing them into the framework of professional institutions.

The intent of this conference, which draws heavily on people outside of medicine, is not so much to answer questions as to define them. To start with, <u>is</u> there a problem in medical education that is appropriate for this group to address? <u>Is</u> there a need for better interpolation of the knowledge of the humanities within the framework of

education in all of the health professions? If so, what is it that we mean and seek? What are our goals, and are the methods we are now using to achieve them satisfactory? Can we improve on these methods? Is there interest among humanists in working with us in the health professions toward some future defined goal?

In the past, I think too often we in medicine have had naive and rather romantic notions about what might be achieved through cooperative teaching efforts involving humanists. Certainly as Dr. Clouser has pointed out in his paper previously distributed to you, we cannot hope that the infusion of some knowledge of the humanities and their way of looking at the world will make humanitarian physicians out of every medical student simply through the exposure. This is an unrealistic goal, and yet I think it is held by some.

In any event, we hope that the focus of this conference will be on questions such as those I have just enumerated. We hope that out of your discussions will emerge some sense of direction which might be helpful in bringing us to something more concrete when the second session of the Institute is held. The next conference will bring together a somewhat larger group of persons, most of them active members of medical faculties, but also some carry-over members from this group.

I would like to say for myself, at least, that I believe we face a set of urgent questions. And I think it is important to investigate these questions, especially at this time. First of all, we in medical education are moving toward a shortening of the medical curriculum. We are moving from the standard 4-4-4 pattern (that is, 4 years of so-called liberal arts education, 4 years of medical education, and 4 years of

post-graduate education) toward a 3-3-3 pattern. In some schools it may be 2-3-3, and at a school like Stony Brook, possibly 1-3-3.

The shortening at the level of preparatory studies causes concern to those who are quite convinced that one ought to be educated liberally first in the tested classical mode, and then move on into the prescribed pattern of a medical education. I think this thesis is up for re-examination. Even if intellectually we might not think it were, the times are such that we are being impelled to do so by young people's hurry and society's needs. The question, then, is how to deal with medical education as it becomes foreshortened and, of necessity, foreshortened in the area of preparatory liberal arts studies.

Second, we will be making this change at a time when medical progress has begun to open up difficult questions about the relationships of medicine and technology to human values -- matters of the utmost concern to the humanist. To what ends shall we put the vast knowledge, the new techniques, the capabilities of biological engineering?

The physician, be he specialist or generalist, must confront these questions of values on at least two levels. As an individual clinician dealing with the here-and-now situation of a patient, he must decide whether or not he will use the knowledge of the new biology for a given purpose at hand.

Furthermore, I see medicine becoming increasingly more involved in the general public welfare, serving various social purposes by providing technical information out of which society must take certain decisions about how a particular technology shall be used. This is an activity I am sure you appreciate fully, as a suborder of all of the

larger questions relating to the matter of how all of technology should serve the social order.

Third (and I hope I offend no one here) I think you know that the humanities themselves are in some kind of crisis. Many persons are raising the question of what has happened to the humanities in the university. Far more learned and better informed persons than myself have wondered whether or not humanists have defected from their responsibilities.

Finally, I think that in a world that is being populated increasingly by a generation that is interested in and starts from images of the concrete, we must examine how we can pursue a discussion of values and principles and concepts. Those of us who are teaching now know that instead of starting from the general and moving to the particular, for the immediate future we must, instead, start from the particular, the concrete, and the existential contexts.

I happen to believe that within the framework of medicine (meaning, again, all of the health professions) we have an enormously fertile possibility for teaching about human values, particularly about how philosophers, theologians, and others approach these matters. I think we can open up possibilities for these considerations within the study of medicine.

I believe also that we should be developing our health sciences centers into institutions that really deal with the sciences and the practical problems they pose for man. That means, therefore, that we need input from those who are cogitators of the problems of man, and

whose point of view is other than the biological. And I think the marriage of these two points of view will be fruitful for all of mankind.

I might go further and suggest that the field of medicine and health could serve as a paradigm--as a source of suggestions and ideas, and even as a base for inculcating some ideas from the humanities during graduate portions of medical education. More importantly, perhaps it can become possible within general university education to think of medicine as a liberal dicipline, as it was centuries ago.

In any case, we do indeed have a whole set of questions to be confronted. This conference group has been selected because of its known, occult, or manifest interest in this subject. I hope that over the next day-and-a-half you can begin to exchange your ideas around this set of questions, or any related set of questions you would like to see discussed. For myself, I am deeply interested in knowing whether at this point in time we can arrive at some delineation of the questions most pertinent to humanists, medical educators, and physicians. Once having delineated these questions, how can we improve communication between our disciplines in the future?

We have selected speakers who occupy a kind of "middle zone" of manifest interest and who will speak from experience. Dr. Sam Martin will address us this afternoon, and later Father Ong and then Professor Clouser each will talk to us about their personal experiences. Group sessions will be small enough to permit you to address yourselves to what has been stated in the advance papers, but please do not feel limited by what is stated.

We are not looking for a new declaration or revelation at the end of this session which will change everything. But we do hope there may be enough congruity of interest and perhaps even of direction so that the material that emerges from your discussions can be useful to the very large number of people who are deeply concerned with these matters. Many of them are like me in not knowing how to approach the teaching of human values in the most productive manner.

I hope we will get through the first stages quickly. Many of these meetings begin with what I call the initial stages of the ballet: as we first confront each other, we feel constrained to demonstrate our terpsichorean prowess. We have a chance to provide a service for a great number of medical and university faculty members who have been sharp in their criticism of medicine and medical education as a human experience. Students today also have an intense interest in this particular interface at this time, and we can serve them, too, by our efforts.

Keynote Address to the

Institute on Human Values in Medicine

THE NEW HEALER

Samuel P. Martin, M.D.
Department of Community Medicine
School of Medicine
University of Pennsylvania

THE NEW HEALER

Health and disease are words like love and hate: there is not a universal meaning. The definitions are influenced by the culture and the individual's private understanding and feeling. For example, in certain communities of Southern USA as late as 1930, one would have said to his neighbor that he was "healthy" even though he was having the ague with its regular chill or having anemia with its lassitude from hook worm. To understand and cope with illness, its symptoms, and its meaning, man has developed an elaborate social system for health care; and he looks to this system for relief of pain, fear and anxiety.

Man's state of knowledge and art defines health, disease, and sickness, the sick role, and the role of the healer as well as the boundaries of the health care system. When society attributed all phenomena to "the divine provinces of the deity," the deity caused all disease and promoted all cures. Disease was caused by sins or transgression which raised the ire of the deity. The healer - the cleric - was an agent of the deity, who could intercede with the deity on behalf of the sick. As knowledge increased, health and disease were redefined and new kinds of healers were sought.

It is this healer and his role that we are here to discuss. How did the healer come about, how is he educated and accultured? How is he kept attuned to the ephemeral and changing nature of his society and his client? Through the ages many people have played the role of the healer: the witch doctor, the cleric, the barber, the philosopher, the biological scientist. Each healer embodied the beliefs of his clients. He was

discarded when his role failed to embody changing beliefs, and a new healer was chosen. Each practitioner was successful in his time because of the tremendous healing capacity which is built into man. Even when the healer used such drastic measures as bleeding and purging, the healing capacity of man overcame the effects of the disease as well as the efforts of the doctor. It has been said that Main Line Philadelphia owes its robustness and strength to the destruction of the weak by the bleeding and purging of the hands of the great physician Benjamin Rush. Only the strong survived.

With the hypothesis in mind that the beliefs, attitudes, and understanding of a society determine the goals of health care, the system of health care, and the healer, let us look back at our evolution to try to find how we got to our present position and to search for future trends.

The first era of medicine with institutionalization of a healer's role began with the formation of man into tribes, and ended with Pasteur's discovery of microbiological agents as causative factors of disease. Until Pasteur's time causation of disease was viewed as polymorphic. Disease was a diffuse imbalance of man and his environment. Such concepts as sin and divine retribution were considered causative factors. Many times the basic observations were valid: for example, malaria was "bad air." On the gust of bad air came the mosquito with its parasite. Even the observation that disease was frequently the result of indiscretion and transgression had a good observational base, but a poor inference of mechansim.

There is a story, probably apocryphal, that Koch took his microscope and cultures to show the great Virchow his discovery, but Virchow refused to look. He told Koch that it was obvious that tuberculosis was

caused by poverty, famine, and war, not that tiny bacillus. At this time Virchow had written, "In reality, if medicine is a science of the healthy as well as the ill human being (which is what it ought to be), what other science is better suited to propose laws as the basis of social structure in order to make effective those which are inherent in man himself? Once medicine is established as anthropology, and once the interest of the privileged no longer determines the course of public events, the physiologist and the practitioner are to be counted among the elder statesmen who support the social structure. Medicine is a social science in its very bones and marrow."

The goal of the early health care system was relief of symptoms. Physicians were plentiful, and their efforts were directed toward relief of symptoms, or support of the patient in his struggle. Medications were based on chance observations, such as cinchoma bark for fever. Physicians classified diseases by symptoms, not etiology: one large class of disease was "fever," which encompassed such diverse diseases as malaria, typhoid, typhus, brucella, and even at times tuberculosis. Because of the frequency of malaria, quinine was used for all fevers. Similarly, opiates were used for pain of all kinds, and foxglove was used for all forms of swelling (the "dropsy"), even though this syndrome included both heart failure and kidney disease.

The discovery of microbiological agents as causative factors of disease in 1947 opened a new era. Instead of the diffuse view of man, health, and disease, the focus sharpened. Medicine as a social cience was shelved. In fact, under the oil immersion lens of this era, we lost sight of man while we focused so sharply on his diseases. The goal of

the system became destruction of the microbiological agent without killing the man. Out of this era came Ehrlich's concept of the magic bullet. Symptomatic medication continued, but many frowned upon it in their search for specifics. To practice in this era the physician had to be a laboratory-trained biological scientist. This course of education limited markedly the numbers available. With such limited numbers and such scientific concern, the physician moved from a position of dependence to a position of dominance in practice. The physician began to lose his broad area of societal concern as he focused on extending his disease-oriented therapy. This era produced the Ehrlichs, Domags, and Flemmings, with their discoveries of salvarsan, sulfonamides, and penicillins.

While this disease-centered concern was flowering, a new movement came on the scene. Scholars such as William James in the United States and Sigmund Freud in Europe, along with a host of others, began to observe man's behavior in this same focused scientific light. It became obvious that there was more to disease than simple microbiological agents -- there were complex interactions between man and the organisms of disease. Infection by agents could occur without production of symptoms and disease. Similarly, the psyche and even a man's way of life came to be considered important factors in disease causations, not only by exposing him to agents but by changing his susceptibility to agents. Diseases related purely to the psyche were recognized. The oil immersion lens could obviously not be abandoned because it had produced the sulfonamides and penicillins, but there had to be a wider view of disease, a broader scope, since causation was viewed as the interaction of man and agents.

Out of this concept emerged the man-centered era of medicine. Our success with our magic bullets led us to believe we could create a diseaseless society. With our sanitation and immunization, with our drugs, and with our good nutrition, whole groups of diseases began to disappear. If we observe the death rate of a disease like tuberculosis, we find a gradual and constant decline after the year 1850. Little or no change in the decline occurred with the introduction of sanitarium treatment. World War I in England and Germany and the post-war inflation of the mark in Germany caused sharp temporary increase in TB death rates, but these returned very quickly to the previously established, apparently constant rate of decline. Even the introduction of Streptomycin did not markedly change the rate of decline. Unless something drastic happens, the disease will soon virtually disappear, as have leprosy and some other infectious diseases.

At the same time, new types of diseases are appearing. The complex chronic, metabolic diseases with possible genetic and environmental causes, are now predominant. Everyone in this audience is peacefully ruminating on his demise. The genes have set the stage, and our eating, smoking, and other physical, social, and psychological environmental activities are playing out the tragedy. The definition of causation is again being extended. Disease is caused not only by agents and by man, but by agents, man and environment interacting. Thus we are entering a new era.

Knowledge about disease, its causation, and treatment grew logarithmically. Before we could be comfortable with the concept of the microbiological agent as the cause of all disease, we were struggling with the concept of mind playing an important role in disease causation.

Hardly having recognized this complexity, we were again thrown into confusion by the evidence that environment and the way of life were also playing an important role. Disease seemed to be not simply the result of one force, but the concatenation of a number of forces. Man's view of causation shifted back to a polymorphic view, but this time based on scientific not on empiric observations. We recognized that our concern with causation must be extended, and that disease must again be viewed in a wider concept.

Research in biology was rapidly providing us with new techniques to alter the course of disease, but these techniques opened a Pandora's box. With the new knowledge we were able to manipulate genes, adding and taking away genetic characteristics. Organ transplantations seem a reality. The control of behavior by such powerful tools as operant conditioning and the use of mind-expanding drugs are here. Taken together or separately, a biological bomb far more dangerous than the atom bomb is now available to us. Will we have to go through the pain of the atom bomb era before we develop a rational approach? An example of our state of confusion is the recent fiasco of heart transplants.

There will not be a moratorium on knowledge, research, and application. There will be more knowledge, not less; more science, not less. It is imperative that the process of utilization of knowledge be explored. Knowledge must be applied in an environment of empathy and love. We do not want less knowledge or less search for new knowledge: we want knowledge about ourselves and our patients, about our community, so we can apply our new techniques in a way that will recognize the true values of man as a member of an ecological unit, a community, and the world.

We are entering this new era unhappy and disenchanted. The physician and the client are at odds on their definition of disease and health, as well as on their expectations of what the health care system can or should produce. The client has accepted a definition like that of the World Health Organization: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity." A large group of physicians deny the breadth of this definition and concern. Another group doubt their capacity to function in this arena, and still another group feel that they over-tout their abilities and over-inflate their clients' expectations. There is little doubt that the gap between physician and client is wide, and the time is ripe for a major readjustment.

This conference could devote its time to many aspects of the problem. However, the physician is our appointed concern. One major question would be: How can we humanize the present-day physician so he can be prepared to approach the problem? The answers may come from studying the concerns of the client. Some clients are disturbed about their relationship with the physician. The average citizen knows and/or feels he knows a great deal about himself. He is no longer ignorant, and he has an interest in knowing more about his illness and participating in decisions about his therapy. Madison Avenue and television show him how his antacid coats his stomach, how his aspirin reaches his brain, and even how his cough medicine reaches his cough center.

He is appalled at the cavalier attitude of the physician in explaining symptoms, disease, and medication, as well as the liberties the physician takes in instituting procedures without informed consent,

for he feels the physician does not have the right to treat or operate without informing him through discussion of the alternatives and consequences. He is equally certain that his own consent must be a genuine sharing of the decision.

Some clients plead for the right to die in peace rather than go through months of painful and at times humiliating treatment, only to die in discomfort. Every day I hear in response to a sudden death, "the lucky bastard!"

Many people are asking about medicine's apparent callous disregard for the economically unsuccessful - the ghetto dweller or the migrant worker. Others ask why we have not provided a portal of entry to health care. For many clients there is no "way in." For many others who try to find a physician, there are a series of rebuffs extending from "I am seeing no new patients" to "I will see you in six months."

There is another great area of concern: the exploitation of patients. Economic exploitation has occurred in cost and frequency of services. The cost of physician care has risen proportionately more than other items in our economy. In addition, there are concerns about the excess of certain kinds of operations: hysterectomies and tonsillectomies, for example, have an unusually high incidence in America. Critical studies fail to find adequate justification.

In the realm of psychological or moral exploitation, within the last month I heard these examples. An obstetrician complaining about a patient seeking an abortion revealed that he rejected the patient because she did not show him sufficient respect. Another physician who treats sexual problems, stated that a very large number of patients referred to him for treatment had had intercourse with the referring

physician or minister. One wonders who was treating whose sexual inadequacies.

It appears the client is telling us something. He seems to be saying that medical and health care must become more humane, and must become a part of our participative democracy. The black, the feminist, the militant, and the poor are demanding a role in shaping the system of health care. Some have even seized institutions of care and brought about administrative changes. Yes! The last stronghold of the philosophy of "the Divine Right of Kings" has been breached, and clients are telling us how we can indeed humanize the present-day physician.

A second question follows: How can we humanize the physician who is now in training and who will be in practice when all these concepts become work of the day?

With this new (again polymorphic) idea of causation, we must seek new goals for the health care system. No longer can we be satisfied with treatment of symptoms and destruction of agents, or even with treatment of the individual. The new system must set its sights on the whole eco-system -- the community. With this goal in mind, we look about for the physician of the future. In all likelihood there will be no physician of the future: "he" will have been replaced by some sort of system.

But systems are populated by men and women -- how, then, will these be produced? John Stuart Mill said in his inaugural address at St. Andrews University in 1867, "Men are men before they are lawyers or physicians or manufacturers; and if we make them capable and sensible men, they will make themselves capable and sensible lawyers and physicians." How wonderfully simplistic, even naive -- but how true,

With this wider scope of medical and health enterprise, we truly need "capable and sensible" men. Unfortunately, neither Mill nor scholars before or after have given us a formula for making capable and sensible men. It has been said, "If you want to make a silk purse out of a sow's ear, start with a silk sow."

Are there ways of making silk sows? As educators we may not have an immediate impact on parents, but we do have the young human being for lengthy primary, secondary, high school, and college education. The health care system of the future will not give up its oil immersion lens. Specialization and science will continue to flourish, but the physicians among the health care team will have to telescope 300 years of social evolution into the next decade. They must go from the philosophy and behavior of the king of yesteryear, to the group presidency of tomorrow. We must find ways of producing intelligent, sensitive, empathic human beings as physicians.

If we want to make such physicians, we must first look at their learning environment. There are few places in society where social interaction, concern, and welfare are as constrained and guarded as in our institutions of medical education and our curricula. Instead of cooperation there is parallel play. Many institutions would not even be characterized as a bureaucracy. Many could be characterized as a series of fiefdoms ruled by warring lords with few budges to each other and one-way budges to society. How can a student be taught to respect his colleagues and work with other health professionals, when his professors are at war with each other and constantly at war with their dean, as well as other deans? To paraphrase the second question, we might

better ask: How can we humanize the teachers so as to affect students who will be physicians of the future?

When one lives and finds his frame in the proverbial glass house, one should be cautious about throwing stones, but since I have been relentless in my questions involving the physician, I would feel a great sense of guilt if I did not toss the last rock. How can we humanize the humanist, the man who must help us all? Some are worried that our humanists are trying to get away from emotions, empathy, feeling, and other parts of our esthetic continuum, and that they are trying to out-science our scientists. At some time we must deal not only with what makes a humanist, but also with how we can facilitate the transmission of his art.

I am reminded of a quotation from Huxley in an essay on the future of man which could well be the embodiment of our problem:

> We should set about planning a Fulfillment Society rather than a Welfare Society or an Efficiency Society or a Power Society. Great fulfillment can only come about by realization of more of our potentialities. Once people grasp what a small fraction of human potentialities are actually being realized and what vast new possibilities are waiting to be elicited, we shall have a new and powerful motive to activate our future.

PSYCHIATRY AND LITERATURE

A Report with Reflections

Walter J. Ong, S.J.
Department of English
Saint Louis University

PSYCHIATRY AND LITERATURE

A Report with Reflections

An account of the work of the Saint Louis University informal seminar in psychiatry and literature which has met monthly, except in July and August, since October, 1968, under the direction of Charles K. Hofling, M.D., and Walter J. Ong, S.J., presented April 13, 1972, at the Institute on Human Values in Medicine, held at Arden House, Harriman, New York, April 12-14, 1971, under the sponsorship of the Society for Health and Human Values.

Dr. Hofling is Professor of Psychiatry and Director of the Residency Program in Psychiatry at the Saint Louis University School of Medicine. Father Ong is Professor of English at Saint Louis University and (since the fall of 1970) Professor of Humanities in Psychiatry at the Saint Louis University School of Medicine. This latter, secondary appointment grew out of his work with the seminar in psychiatry and literature and to a lesser extent out of lectures on the phenomenology of verbal communication which he has given from time to time for the Department of Neurology and Psychiatry.

The seminar in psychiatry and literature is made up of the residents in psychiatry (normally numbering around 15) at the David P. Wohl Mental Health Institute at the School of Medicine and of some five or six graduate students working toward the Ph.D. in English at Saint Louis University.

1. Introduction

The humanities can contribute in a variety of ways, it would seem, to the development of health professionals. The contribution I propose to treat here is, even upon short reflection, a not unlikely one. It has developed in an area of medicine singularly hospitable to the humanities, that of psychiatry. Ingenious procedures for uniting the humanities and medicine on less propitious grounds might be more intriguing: hitching poetry to ophthalmology by planting copies of Jonson's "Drink to me only with thine eyes" in ophthalmologists' waiting rooms, or working studies

of Macbeth's witches' brew into courses in pharmacology or dietetics. The activity I am reporting on has been much less clever than that. But it has the advantage of being not merely a proposal. It is an ongoing program now in its third year. Moreover, despite the fact that behavior of fictional characters has interested psychiatry at least since Freud discovered Oepidus, our informal seminar on psychiatry and literature at Saint Louis University, in which both resident M.D.'s in psychiatry and doctoral students in English educate one another, is an unusual operation. Dr. Hofling knows of somewhat similar activities at the Menninger Foundation, the University of Colorado, the University of Cincinnati, the Medical College of Virginia, and the Albert Einstein College of Medicine of Yeshiva University (New York), but all of these appear to differ significantly from ours.

2. Genesis and Purpose of the Seminar

The seminar was initiated basically to further the training of the residents in psychiatry, all M.D.'s. It is an informal seminar in the sense that it is not listed in the University's printed course offerings, but it meets with absolute regularity, once a month for ten months of the year.

It has been the conviction of Dr. Hofling, who suggested the seminar, that other ways of learning about human beings in depth available to psychiatrists can be supplemented by the careful study of literature. The seminar members from the Department of English, however, are not on hand merely to implement this study for the psychiatry residents but also to learn themselves. They find that psychological study can deepen their insights and sharpen literary issues and also aesthetic and moral issues

which otherwise remain unnecessarily vague.

Dr. Hofling has long been interested in psychological studies of literature. He did graduate work in English before entering medicine and, besides studies in the professional psychiatric journals dealing with recognized psychiatric and psychological material has published studies on such subjects as "An Interpretation of Shakespeare's Coriolanus," The American Imago, 14 (1957), 407-435, "Thomas Hardy and The Mayor of Casterbridge," Comprehensive Psychiatry, 9 (1968), 428-439, and "General Custer and the Battle of the Little Big Horn," Psychoanalytic Review, 54 (1967), 107-132. This last is a study not only of Custer's personality structure, but also the question, Why are so many writers and readers fascinated by the figure and behavior of Custer?

My own interest in literature connects with work which I do on more comprehensive matters and which, I have been told and believe, is hard to classify. This work has been identified as a phenomenological study of cultural history, focused on the development of the media of communications, from the primary oral culture of primitive man into the ancient and medieval arts of grammar, rhetoric, and logic or dialectic, and on through the Renaissance and the post-Renaissance encyclopedic era into our own electronic world. The title of one of my books may illuminate my concerns, or at least give them a certain aura: The Presence of the Word.

In an article on "Psychiatry and Great Literature" in the Saint Louis University Magazine, Vol. 42, No. 4 (Winter, (1969)-1970), pp. 22-26, Dr. Hofling has reported on his thinking regarding the operation of the seminar.

> Great novels and great plays for the most part present patterns of characterization which are internally consistent and true to life. They furnish a student of human nature with material which is both subtler and deeper than any which he is likely to encounter elsewhere at an early stage of his psychiatric training. Such material is present in much finer detail, in better balance and showing greater selectivity than in most case histories, and in greater depth than the psychiatric trainee is likely to reach in any of his early diagnostic interviews or even in his early therapeutic efforts. (P. 25).
>
> Perhaps the most important things the would-be psychiatrist can gain from studying such works is a certain conviction about an internal consistency in human character and in the plot each human life may be said to embody. The psychiatrist, in conducting his initial interview with a patient, may be compared to a person opening a new novel, of say, twenty chapters, turning to Chapter Ten and reading it. The most experienced psychiatrist is not a mind-reader and so he--and still more the beginner--is often deeply puzzled by what he first sees and hears. The greatest single asset the young psychiatrist can acquire does not pertain to an encyclopedic knowledge of human behavior. It is the conviction that the bit of behavior he is privileged to witness (no matter how unconventional and peculiar) will ultimately prove to be intelligible. Like a reader who happens to open a great novel in the middle, he knows that the episode he is considering is logically and consistently based on "chapters" that have gone before. (The parallel is, of course, less close with respect to future chapters. In the novel these have already been written, whereas in real life the patient--possibly with the psychiatrist's help, along with that of others--still has to write them.) (P. 25).

One thing should be kept clear: we do not proceed on the supposition that reading or studying literature is particularly therapeutic. Like any number of other activities, reading or studying literature may be used for therapeutic purposes--so might tennis or crossword puzzles or mountain climbing. We use literature for the psychiatrists, not for their patients, taking it not as in any way directly therapeutic but as informative regarding human behavior.

Moreover, what we do is not the same as literary criticism, though it may often be of considerable use to literary critics. We look to literature for what psychiatrists can learn from it about human behavior.

Many literary features of the works which I myself as well as other critics would consider of capital literary import we simply do not consider in this seminar, although not infrequently we do remind ourselves that other features besides those we consider are there.

3. Procedure

The procedure in the seminar is very simple. The meetings have always been held in the home of Dr. Hofling. The one monthly session begins at 8:00 o'clock in the evening and lasts a good two and one-half hours. Husbands or wives of married participants are welcome if they wish to come. For two or three out of some twenty-five meetings another faculty member from the Department of Psychiatry has dropped in. Requests from others, inside and outside the University, to join the seminar are politely but firmly turned down, if only because the number of those for whom the seminar was specifically designed is large enough as it is. Because of other duties, not all members of the seminar can be at every meeting. A good and effective gathering is often one of about a dozen persons or so. There is no problem when the attendance runs over twenty, or if it falls a bit below twelve.

Each seminar treats one particular work, such as Joseph Conrad's The Secret Sharer, Shakespeare's Othello, Arthur Miller's Death of a Salesman, Faulkner's The Bear, or John Hawkes' Second Skin. All members of the seminar are expected to have read the work in advance and are encouraged to look up any commentaries they may have time for.

It is generally expected that I open the discussion. My way of doing so varies but may typically consist of remarks about the author and the background and history of the work (including its appeal or lack of

appeal when it appeared), leading into one or more of the three approaches discussed here below. Dr. Hofling then usually adds some comments of his own, and with the pump thus primed by two initial sets of comments, discussion begins on whatever matter seminar members wish to take up.

4. Approaches to the Literary work

One can conveniently distinguish three basic ways of approaching a work of literature for our particular purposes. We find it well to keep these three ways distinct in our minds, if only to know what we are talking about, although of course at times we can join them with one another.

First, one can consider the psychological interaction of the literary characters with one another or with their surroundings.

Secondly, one can consider the psychological aspects of the reaction demanded or induced in the audience or the reader.

Thirdly, provided one has access to information about the author's life from other sources, one can use the literary work in connection with the author's biography to throw light upon the psychological forces at work in the author's own life.

The need for information from outside the literary work to make feasible any biographical excursus has been apparent both to the residents in psychiatry and to the doctoral students in English. Fiction, in the broad sense of this term as imaginative verbal creation, generates aesthetic distance. All fiction of course tells something about the author's sensibility and cultural heritage: it indicates some of the things he knows and reacts to, including, in the original text at any rate, the language he speaks, and so on. But it gives little or no information

at all regarding his biography or psychological history. From the characters in Shakespeare's plays and their behavior, we have no idea of Shakespeare's own personal life story or psychological problems. T.S. Eliot has put it well in his essay on "Tradition and the Individual Talent:" "Poetry . . . is not the expression of personality, but an escape from personality."[1] In Eugene O'Neill's plays or Edgar Allan Poe's poems, however, the author's personal problems do obtrude, and the plays or poems are less successful for it.

Paradoxically, the aesthetic distance from "real" or nonfictional life appears to be what makes the work of fiction so revealing regarding psychological structures. Detached from the author's own personal hang-ups and established in a fictional world which is a model or paradigm of the nonfictional,[2] the fictional character is allowed to act out his or her own structures under the influences which play on him in the fictional world the author has created. When the author's own existence in the form of his own personal problems intrudes directly, the fictional characters show up as somewhat interfered with or contrived, both aesthetically and psychologically. They no longer have their own say.[3]

---

[1]T. S. Eliot, Selected Essays, new ed. (New York: Harcourt, Brace and World, 1960), p. 10.

[2]A fictional world is always drastically simplified, however complex it may seem to be, for no fiction is truly so dense as man's existential life, though good fiction can often suggest this density more impressively than real life itself ordinarily does.

[3]It should be noted that since aesthetic distance is a normal concomitant of fiction, one can play fictional games with it, too. Having set up fiction in its own world of "once upon a time," marked off from the world of nonfictional life, one can move back and forth from the fictional to the nonfictional, as in action theater. But this movement develops out of the fiction, so that the real life is no longer real life. It becomes real-life-cultivated-for-fiction.

The reasons why fiction is useful to teach psychiatry lodge in this dialectic of nonfiction and fiction.

However, if we know something about an author's life from outside his text, it may well be that we can discern what particular structures in his life a particular work connects with--The Winter's Tale with Shakespeare's later years, and so on. For any work of art is extruded out of the fabric of an individual's life and consciousness by certain pressures coming at a given time in the individual's own particular existence. But in being extruded, the work detaches itself from its source. "Now let me tell you a story" or "once upon a time" and other such signals indicate the point at which the detachment is effected.

5. Some Particular Findings

Coming to the literary work through each of the three approaches just mentioned, we can look to the kinds of findings the seminar yields and to the awarenesses it develops. In doing so, we must remember the principal immediate purpose of this seminar: to alert those learning psychiatry to psychologically significant features of human behavior. Much literary criticism goes far beyond where we go. Our procedures are not conceived of as a substitute for literary criticism, but as learning devices for psychiatrists.

It will be noted that the descriptions as I give them here are often cast in psychiatric--usually Freudian--terms. These terms do not provide access to everything in the literary work, by any means, although they do provide access to a great many insights of high value to literary criticism, too. The use of psychiatric terms is not intended to be reductionist, and I must say that I really do not find any strong tendency

to reductionism among the psychiatrists in our seminar, who appear uniformly aware that everything in the work is not reducible to psychiatric categories. Nor are the psychiatric terms here used proposed as irreformable. If going psychiatric concepts do not fit the fictional actuality, we have to do with them what one does with them when they do not fit existential actuality: discard them or remodel them. The seminar can thus serve to encourage psychiatry's self-criticism.

With these prenotes, let us turn to the three approaches to fictional works and some of their results in our seminar.

(a) Interaction of the literary characters. The psychiatrists in the seminar commonly observe that novels or plays populated with "well rounded" or "full bodied" characters -- such as, for example, those in Othello or Hamlet or The Return of the Native, as against those in Ben Jonson's Volpone or in medieval morality plays--provide far more information about the principal characters than most psychiatrists ever succeed in eliciting from most patients. Surprising as this may seem at first blush, on reflection it appears quite plausible, for in the fictional work information about the character feeds in from the other characters and from the narrator's own voice as well as from the character in question himself. Moreover, if the fiction works, the author has highlighted the salient and psychologically credible points of interaction between characters.

To be more specific, we can retail some of the information which turned up in our seminar discussions. The Stranger by Albert Camus is a good work to start with. It is commonly treated in critical literature as being an account of a person suffering from some kind of cosmic ennui who commits a murder, as he does everything else, without any commitment

or motivation. This explanation is not very satisfactory not merely because it appears psychologically implausible and indeed impossible to act without motivation but because of the tremendous appeal that this story has had since it appeared in 1942. Without taking time to go into the reasons for our conclusion, we can note that at the end of our discussion it was entirely evident that the protagonist, Meursault, has a pretty clearly defined personality structure, arrested at the anal stage and showing the typical passive aggression of the very young child, who can resist chiefly by not doing. Meursault's character appears basically not regressive, but simply arrested at a very immature stage. His mother is a large figure in his life and through the story, but his father as well as Perez, his mother's friend, remain only very dim figures with only a slight suggestion of any kind of Oepidal conflict or any triangle at all. Meursault has not fully entered even the Oepidal stage. He is extremely aggressive against women in a passive or indirect way. He flatly refuses to marry his lover or even tell her that he loves her. He is attracted to Sintes, who is a woman beater, and the Arab he murders is both a defender of women and a kind of symbol of effeminacy himself.

This kind of analysis, which is very solidly and circumstantially grounded, is obviously illuminating to residents working in psychiatric clinics. It is also invaluable to students of literature, for it enables them to go beyond the routine and banal statement that Meursault's life is hollow and meaningless by showing that it has a particular kind of hollowness and meaninglessness deriving from his deprivation of true maternal love, suggesting that our present malaise, which Meursault paradigmatically registers, may be a quite specific kind of malaise.

We must not take these psychological diagnoses as implying for literary criticism conclusions which they do not imply. First, the fact that Meursault has an arrested, infantile character does not imply that Camus' art is infantile. Quite the contrary: it takes consummate art to portray a character of this sort with Camus' dead consistency. How reflectively Camus was aware of what he was doing is of course another question. An artist need not be reflectively aware of the psychological structures he is dealing with. As an artist, he works with such structures by feeling them, registering them in the process of literary creation. In addition, he may or may not have abstract or scientific understanding of them. James Joyce did have considerable abstract understanding of depth psychology, but he still generated his best works out of his creative imagination, not directly out of psychological text books. Eugene O'Neill likewise had some understanding of depth psychology, but, in contrast to Joyce, he wrote his works too much out of naked understanding mixed with untransmuted autobiography, and too little out of his creative imagination. Insofar as O'Neill's creative imagination was not in so full control of his productions, they stand at a much lower level of achievement than Joyce's.

Secondly, the fact that Meursault has an arrested, infantile character does not of itself imply that his readers are typically arrested and infantile. Given other supporting evidence, it might conceivably imply this, of course. But it also may imply merely that the problems engendered during World War II were such as to make this arrested, infantile stage intriguing or inviting. Or that these problems were such as to make many feel that the whole world outside themselves was living in a state of arrested infantilism. Or many other things.

Or, in various ways, reading The Stranger might simply be a substitute for actual regression.

Thirdly, and finally, psychological diagnoses of Meursault or other characters does not imply that there are not various levels of meaning in Camus' story, such as its allegorical reference to the French-Algerian situation or to political repression generally. On the contrary, psychological understanding of the protagonist and other characters should enable us to examine such additional meanings more circumstantially.

Let me simply mention some of the more striking, because more or less unexpected, conclusions we have come to regarding other works. Samuel Beckett's Waiting for Godot obviously achieves much of its effect by making passivity also some kind of threat. The psychiatrists found considerable evidence of "primary process" thinking in Godot. We were puzzled by the fact that, while one of the classic psychological sources of difficulty rooted in infancy is waiting for mother, in the Beckett play, this problem is transmuted into waiting for some kind of father figure. The widespread appeal of Godot makes this transmutation particularly intriguing.

Franz Kafka's work, The Castle, produced some surprises, at least for me, though I have long known it well. Since the psychological trappings are so much in evidence--dream-like sequences, all kinds of ominous authority figures, and so on--I would have thought that this and other works of Kafka would be very easy to handle psychiatrically. As a matter of fact, it was not at all easy for the psychiatrists to get into the work, largely because it provided no full-bodied characters. But once we did get in, we came up with some interesting conclusions, or so I

believe. Kafka achieves the eeriness which marks this and other works of his largely by a very simple device: he presents characters who have virtually no past. Only at one point, it appears, K. reflects, very briefly, upon his past--a scene from his boyhood which, significantly, involves a wall. Other than this, virtually nothing. The sense of aimlessness and lack of motivation is produced quite automatically and almost mechanically by eliminating any suggestion of the real past out of which motivation would have to spring. It is interesting that although the story is told from inside K.'s mind, very little of his mind is directly revealed because without his past we have very little access to his consciousness. Of course, in a dream state, connections with the past are disrupted too, although not quite this way.

In Charles Dicken's Oliver Twist the doubling of many of the characters suggested itself as somehow significant: Oliver and the Artful Dodger, Fagin and Mr. Brownlow, the good young mother and the good-hearted bad girl, and so on. The title itself has a strong suggestion of doubling since the term "twist" comes from the same root as "two." I am sure that something could be made of this in terms of the general tendency of stories to set up dualities expressing tensions, but we didn't go into this very far.

Fyodor Dostoyevsky's Crime and Punishment was of course richly productive. Raskolnikov is obviously using rationalization as an escape from reality and shows definite schizoid tendencies. This is of course no news. Perhaps it is a little more news that the woman pawn broker is a clear surrogate for Raskolnikov's mother. Raskolnikov's carefully wrapped dummy package which he delivers to the pawn broker before

murdering her is classic psychological equipment: the gift that is no gift. This is exactly the kind of gift his mother constantly presents him with through the novel. Raskolnikov lives through a fascinating and distressing psychological history: he externalizes his internal conflict by perpetrating a real murder. But he thereafter develops morally, for he manages somehow to face his real guilt and to deal with the real situation. How much he finally learned to love others remains, we thought, doubtful. But he had at least rid himself of his rage by facing up consciously to its tragic results.

John Hawkes' Second Skin contrasts interestingly with The Castle and Waiting for Godot. Hawkes' work is definitely avant-garde narration, the sort going well beyond Kafka or Beckett in its Gothic qualities and in the work it demands of the reader. Yet, beneath the complex surface of the writing, one finds in fact full-bodied characters of the sort which psychiatrists can handle directly. Skipper (otherwise known as Papa Cue Ball and Edward) proves to be a quite durable person. He is not exactly narcissistic in any ostentatious sense but his investment in others is slight and gives very quickly. This creates problems, but problems which he can somehow manage (for himself) often by dint of sheer psychic vigor. Skipper leads a life designed by style, not related to other persons. Hawkes' writing itself is highly stylized and obtrusive, and thus reinforces the story of Skipper's life. The novel has an admirable unity.

The littoral and pelagic settings for the Hawkes work suggest Ernest Hemingway's long short story, The Old Man and the Sea, another fiction we studied. This story works by situating both the old man and the boy in the latency period. The old man has regressed to it, the boy has

just grown up to it. The effect on the reader--about which we shall say more in a moment in the case of other works--could be to make him simply regress by identifying with the old man and the boy, but at the start and the end of the story Hemingway distances his characters as objects. This saves the story from being melodramatic. (The seminar findings suggest that one could define a melodrama as a work which invites the reader to regress but forbids him to become aware of the fact that he is doing so, at the penalty of destroying the effect desired.)

Arthur Miller's play Death of a Salesman generated one conclustion which might be of mild interest, namely, that Willie Loman's wife had a far more demoralizing effect than might be evident at first glance. She was largely responsible for the inability of Willie and their two sons to grow up, although Willie was not without his own share in the responsibility.

In Edmond Rostand's Cyrano de Bergerac, Cyrano comes off pretty well as a human being. His own conflicts are so great that he not only could not be normal himself but also sacrificed a woman to his conflicts. By renunciation of ordinary direct personal gratification he actually achieved gratification by living through another, the friend who became the husband of the woman whom he himself loved. This is often a very stable psychological compromise and one about which Anna Freud has written. We might suggest that humanly, if not dramatically speaking, it would have been better if Cyrano had levelled with everyone and sacrificed his own special kind of security.

(b) Psychological aspects of the reaction demanded or induced in the audience or reader.--Cyrano de Bergerac is interesting for its

effect on the reader. It was first acted in Paris December 28, 1897. It so happened that the Saint Louis University Library copy which I used for the seminar had this inscription on the front flyleaf: "Petit souvenir de ma sincère amitié. J. Alexandre. Paris, le 29 mai 1898. ! Le plus grand succes de l'hiver parisien!" Since the title page indicates in print that with this issue, which the inscription shows was in circulation by May of 1898, 88,000 copies of the play had already been published, we can see how the play must have seized the French imagination, selling 88,000 copies in five months -- and 88,000 copies of a play, not a novel. It is not hard to see why the character of Cyrano caught the imagination of Frenchmen so strongly at this time. The conflicts brought about by the defeat of 1870 and reflected and intensified in the Affaire Dreyfus made it very easy to identify with a character registering such tremendous suppressed conflict as Cyrano's.

J. R. R. Tolkien's trilory, The Lord of the Rings, has had a tremendous following, particularly among college and university students over the past five or six years. The seminar has worked with the first volume of the trilogy, The Fellowship of the Ring. It was evident that not much could be done regarding the interaction of the characters if they were regarded as adult human beings, for they do not function as such. But study of the reader's reaction called for by the story was very productive indeed. The Lord of the Rings presents the late latency period as it is remembered. The reader is invited to regress to that period. "Hobbits" are late latency size, about four feet high. They live in houses which are carefully described as having rounded windows and doors, giving off an aura of extreme protectiveness (in the latency period the child has not

broken out of the home into the tribe). Hobbits do not wear shoes (going barefoot is common in the late latency stage), they are highly oral--Tolkien describes huge feasts in lavish detail--and they are likely to solve their major problems by simply going to sleep. Hobbits have, moreover, the artisan interest of the late latency period, and they are only half-literate. As the latency world is intersected by certain adult figures, so is the hobbit's world, by figures such as Strider, who is a fully human being (in effect adult) knowing much more about why things are the way they are that Hobbits can ever know. The overwhelming appeal which this kind of story has had during a good bit of the last decade has fascinating implications for public health. Regression can of course be good as well as bad: simply playing a game can be healthily regressive. Still, a high frequency of regression can be symptomatic. One can readily think of many other strong regressive tendencies today, including even interest in environment in some of its aspects, for environment, important though it is, can also be narcissistic: no matter how far out it extends the center is always reassuringly me.[4]

---

[4]Those who know the history of the now old New Criticism developed by F. R. Leavis and others in the 1930's will be aware that much of the battle of the New Criticism was against the practice of remitting literature to the world of latency or early academic puberty rites. Perhaps because of the impact of the New Criticism, but I suspect on other independent grounds also, I myself -- if you will pardon a personal reference--have always found myself bridling at the kind of demands this trilogy of Tolkien makes on me as a reader. Euphemistic daydreaming about late-latency worlds does not seem to me to be a very worthwhile diversion, although I recognize the magic in many of Tolkien's divagations and especially in the names he conjures up. I have a suspicion of my own that there is, however a permanent and probably productive residue of latency remembrance, particularly in males.

(c) Connection with the author's biography.--This approach is properly a psychological study in biography undertaken through examination of an author's work in relation to other matters in his life, as these are known from other sources. For example, in the article earlier referred to, Dr.Hofling has treated some of the ways in which a protagonist in Shakespeare's play Coriolanus correlated with Shakespeare's own life at the time the play appeared. Much more can be done in the case of authors whose biographies are less sparsely documented than Shakespeare's.

In August Strindberg's Miss Julie one can make a close correlation between the psychological structures of the characters and Strindberg's psychological problems. I shall not go into this work here, but simply instance it as a particularly fertile production for the study of biographical connections. The biographical import of this play is in fact quite well known, as it is likewise in several of Eugene O'Neill's plays.

A variant or offshoot of this third, biographical approach which has been touched on in mentioning Ha es's work above but which the seminar does not normally go into except perhaps in passing, is the relationship between the characters and their interaction on the one hand and, on the other, the author's style. Flaubert's Madame Bovary, for example, invites consideration of this relationship, which did in fact come up when the novel was studied in the seminar. Emma, it appeared, was what has been called a "love.addict," looking for love to move in her direction, for men to love her, and hoping to relish this experience. Her way of looking to a man to love her and thereby of viewing herself not directly but rather through his putative love gives her a distance even from herself. Significantly, as critics like to point out, Flaubert presents

in his narrative a great many views out of windows, particularly downward views. The sense of distance, of detachment, which registers in the character of Emma is mirrored in Flaubert's own style, both as it exists in itself and as he actually ambitioned and described it. The style has a curious detachment from his subject, novel in his day though no longer so. For the assiduously detached narrative voice is commonplace today, picked up largely from Flaubert. Critics have hailed Madame Bovery as a book "about nothing," so uncommitted is its point of view. Looking to Emma's personality structure, we can see that the "nothing" corresponds to a curious void in her character.

Analysis of this sort, relating characters and the author's style, is difficult but perhaps establishes connections between psychotherapeutic aims and literary criticism more intimate than other types of analysis.

6. Reactions of Seminar Participants

This last mentioned analysis, of characters vis-á-vis style, also serves to differentiate somewhat the two groups of students in the seminar. It is highly satisfying to the Ph.D. students in English, who commonly feel that the psychiatric or psychological approach taken in this seminar because of the purpose of the seminar is indeed highly informative but also narrowly specialized. Conversely, for the most part, the psychiatry residents feel themselves a bit off balance when discussion moves explicitly into style or into literary history or questions of genre, although they do not feel at all so disadvantaged in questions regarding cultural history. Despite this difference in orientation, the two groups have proved extremely friendly, and in the seminar itself there is virtually no polarization at all between psychiatrists and

students of literature as such. Differences of opinion mostly cut well across such groupings. In one case, a graduate student in English seemed on his first participation in the seminar to be imputing to the psychiatrists a reductionism which, whatever clues he may have been picking up, they did not really intend, as he himself soon became aware. He has since become one of the most insightful contributors to our discussions.

7. Some Possible Conclusions

The conclusions which the activities of the Saint Louis University Seminar in Psychiatry and Literature have suggested to at least this participant are sweeping and can only be touched on here.

First, it is clear enough and no news that psychiatry is deeply affecting literature. The direct effect particularly of psychoanalysis on the content and style of literature is well known. Writers acquire some knowledge of depth psychology and use it consciously in their creations. James Joyce is a classic example. Would that more of the other examples were so good. Depth psychology has of course subconscious effects, too, as well as those it enables the author consciously to achieve.

Secondly, depth psychology has affected the interpretation of literature as well as of history and biography. This, too, is well known and is not infrequently resented. What warrant does Erik Erikson have for psychoanalyzing Martin Luther? Or anybody for psychoanlayzing Hamlet? Our seminar suggests that there is in fact often more warrant for "psychoanalyzing" a fictional character than a patient since, as the psychiatrists all pretty well agree, in a good play or novel the reader often finds out more about the protagonist as well as other major characters than a psychiatrist commonly finds out about a patient who is not in

formal psychoanalysis. We can suppose that history supplies comparably rich materials on some persons it treats.

All these purported invasions of literature or history or biography by psychoanalysis do no. trouble me. Any light that depth psychologists or anyone else can shed on the mysterious world of literary creation is entirely welcome, provided we guard against reducing everything to psychiatry. In my own limited experience, reductionism is a threat not so much from psychologists or psychoanalysts so much as from some literary critics unable to swim very well in the depths which psychology opens to them.

A reverse invasion, however, does interest me, and suggests a third possible conclusion. Noting that psychiatrists treat literary or historical figures like patients, I am beginning to suspect that they find it feasible to do so because they are used to treating their patients like literary figures. Freud discovered Oepidus in a play, and psychiatrists generally in their writings show themselves often widely familiar with significant literary works. Is psychotherapy dependent upon the development of literature? And of literature in the strict sense of written productions? Oral performance does not ever produce the "well-rounded," "natural" characters we find in the Greek drama (the first verbal genre controlled by writing) or in Shakespeare or in Hardy. Oral tradition figures--those in Homer, for example--are type figures: wily Odysseus, wise Nestor, proud Achilles.

Depth psychologists would be the first to admit that their discipline is culturally conditioned in its origins and history. I am suggesting the possibility of a very specific kind of cultural conditioning: psychiatry may work by seeing real people through fictional lenses, consciously or unconsciously employed. This is not meant as

dispraise at all: seeing real people through fictional lenses may be the best or even the only way for psychotherapy to effect cures. Modern psychotherapy perhaps could not have come into being had not literature developed as it did. If this is so, if depth psychology has achieved its insights through familiarity with fictional as well as real characters, then our seminar itself is living out psychologically the old recapitulation theory: it is reconstituting ontogenetically, in the development of these particular embryonic psychiatrists, the philogenetic patterns which produced the science in the first place, moving from interpretation of the world of the creative imagination, which is the mysterious world of play defining human life on the one side, to the interpretation of actuality, or the work-a-day world which defines life on the other side.

Reflections on the development of psychiatry suggest other problems our seminar has not yet looked into very intently. Why does our age favor the particular literary works it does? Stories are not told the way they used to be. At least many of them, especially avant-garde stories, are not. Are they specializing in particular kinds of characters and situations? What do our own distinctive predilections for certain fictional characters and situations say about the personality structures and problems peculiar to our own present moment in history? Like other works of art, literature at its best responds not only to enduring or recurring situations but also to quite specific developments in the history of consciousness, reacting to these often quite precociously or presciently. What does the popularity of Kafka's The Castle or of Camus's L'Etranger or of Tolkien's The Lord of the Rings or of Herman Hesse's Siddhartha say to those interested in psychic health today? Or, to put it perhaps more positively, what do such works say about the particular longings of

the human heart in our time? The fact that literature builds upon problems, often very deep and distressing problems, does not mean that today's favorite works need be saying anything particularly sinister, or at least anything more sinister than Oepidus Rex. But they are probably saying something a bit different and quite specific.

Thus far our seminar has been studying literature somewhat temporally, examining works from all periods for what light they can furnish regarding understanding of patients always. Such study is essential and highly illuminating. But we could also examine the literature of our time in its prophetic manifestations for our own age. This we have done very little if at all. I hope that with the experience we now have we may be able to examine literature to understand better this age's own particular agglomerate of hopes and fears. Doing so should enable us to compass more circumstantially the moral and other crises of our time in their relation to psychic healing. It is often remarked that depth psychology has managed no real breakthroughs for a good many years. Perhaps one reason is that it has not sufficiently updated itself in terms of evolving psychic structures. The psychological study of urgent contemporary literature might well foster such updating.

8. Replication

In addressing this Institute on Human Values in Medicine, I have reported on an ongoing project clearly relating the human values discernible in literature to the professional concern of a physician, which is therapy. I see no reason why our procedures cannot be replicated and improved in other psychiatric teaching situations.

But the association between human values and therapy which I have

reported on is in a sense a facile association. The storyteller or dramatist and the psychiatrist inevitably occupy common ground, that of human behavior in thoroughly social settings. One would like to know if any of the ways of associating human values and therapy which we have found useful can be deployed into other territory. Is the psychological study of literature useful or desirable for those in surgery, cardiology, radiology, or internal medicine? Should every physician be given the kinds of insights we have been working to achieve? I leave these questions for discussion by those closer to these and other medical fields than I am.

PHILOSOPHY AND MEDICINE

The Clinical Management of a Mixed Marriage

K. Danner Clouser
Department of Humanities
College of Medicine
The Milton S. Hershey Medical Center
The Pennsylvania State University

PHILOSOPHY AND MEDICINE:

The Clinical Management of a Mixed Marriage

INTRODUCTION

My appointed task is to reflect publicly and helpfully on teaching philosophy in a medical school. This is a practical undertaking the likes of which the likes of us like neither to do nor to listen to others do. Our types would rather witness clean, subtle, rigorous work on a substantive issue. To maintain interest, a discussion of approaches to education should at least be cleverly written. I will spare you that. What follows reads like an Army Field Manual. And there are similarities beyond mere halting style. Entombing obvious observations in lofty language may be one such. Another would be fulfilling that ubiquitous need for a place to start beginners, a saying of all that which goes without saying. Teachers call it a "prerequisite."

But perhaps the obvious needs to be said. Maybe for a constructive discussion it is not enough to know the material; maybe we need also to know that the others know it. Then, with that common core said and done, useful discussion can be unhesitatingly launched. The purpose of this paper is not so much to help <u>you</u> as it is to help <u>discussion</u>. It is simply an ordered compilation of thoughts and observations during two and a half years on the job.

My aim is primarily to stir you to think of ways your own discipline might relate to the medical context to the benefit of both. There is no doubt a suppressed premise involved; namely, if philosophy can be of relevance, surely anything can! Hence philosophy becomes the chosen paradigm.

My plan is not to discuss substantive questions: the non-philosophers would not understand and the philosophers would fight. I want simply to illustrate some philosophical concerns which are helpful in the medical world and to suggest the insights and fun in overlapping the two disciplines. Hopefully, these reflections will become the occasion, if not the prod, for you to conceive of analogies in your own discipline or further possibilities for philosophy itself.

More than just course descriptions must be said in order to accomplish my task. The context in which these concepts are to live and move must be analytically described if the rationale for the courses is to be seen. To that end I want to say things in general about Humanities in a medical school: why they should be there, what the students need and want, and some of the formats available for delivering the goods. Perhaps, after such a conditioning fanfare, the details of the conceptual intermingling will make better sense.

PART I

Humanities and The Medical School

A. "Humanities"

This name itself may be mildly misleading to the medical community. It readily becomes synonymous with "Humanitarian" -- and then, just as the Pathology Department makes the student a pathologist, and the anatomy department makes him an anatomist, so the humanities department is expected to make him a humanitarian. This is a fairly insidious progression, for not only does it rob humanities of its true calling, but it absolves other departments of a responsibility that should be shared by all. To compartmentalize the responsibility for humanizing is to confuse virtue and knowledge. Our students will be humanized, if at all, by witnessing compassion, gentleness, and empathy manifested in patient interviews, in rounds on the wards, in their preceptor's office--and not by studying a body of knowledge.

The Humanities should remain academic deisiplines and not get caught in the role of specialists on bedside manners and professional etiquette. Basically ours is an academic role even in the medical school. Each discipline should be working to interrelate conceptually with some discipline of the medical world. They should be seeking areas of overlap, where each from its own perspective, methods, and resources can raise questions or shed light to the mutual benefit of both. It is an interdisciplinary enterprise aiming for new insights and understanding. The virtues and strengths of each discipline must be maintained if they are to relate profitably to each other. The humanities disciplines should not be asked to dilute or pervert, but only to ferret out those concepts,

methods, maneuvers, insights, and distinctions of its own discipline which might conceivably mesh with those of another discipline. This is a matter of focusing and probing in order to delineate new areas of concern and cooperation.

But having insisted on the disciplinary and academic integrity of humanities in a medical school, I must now back off a bit. There is of course a clinical, practical, or "service" side to the basic, theoretical, or academic side which I have stressed. There are at least three distinct areas where this can be seen. i) The overtones and implications of some humanities courses are bound to stimulate "humanitarian" concern. A by-product, say of a literature course, might be genuine empathy for the horror of dying, the pain of loneliness, or the imprisonment of poverty. Or after extensive pondering of ethical issues, the student might easily be more alert to lurking moral problems where heretofore he had seen none. ii) It would be appropriate to have some explicitly clinical courses. For example, a course on "Death, Dying, and Grief" would help the students to work through their own fears and anxiety, to explore the literature on the subject, and to develop skills in working with the dying and the bereaved. Or a course on "Professional Responsibility" could alert the students to the implications of their role, lead them to a measure of self-awareness in that role, and prepare them for the defenses they may develop and the temptations they will confront. iii) It is also within the compass of the department to be a catalyst for efforts toward humanitarian reform. This is not necessarily its job, but it has the advantage of being a "naive" newcomer, unencumbered with political entanglements and vested interests. This might have to do with anything from curriculum reform, to a committee on human experimentation, to patient complaint.

Or it might take an educational turn, setting up workshops dealing with drug abuse, or with pending legislation and medicine, or with suicide risks among professionals.

But again, all these are but natural outcroppings of firmly established academic disciplines. Needless to say, those involved cannot be disdainful of practical fallout from their discipline; indeed they would hopefully seek it, attempting to relate to the clinical needs wherever they can. But notice that the humanities are not necessarily providing the motivation to be "humanitarian." On the other hand, if the student somehow becomes so motivated, then what the humanities have to offer is guidance in how to manifest this concern with intelligence and effectiveness. For example, if the student is committed to acting normally, then an understanding of ethical concepts and maneuvers may help him discover the right action in a particular situation.

Some may still wonder about "the humanizing effect." How can it take place? Primarily I have wanted to emphasize that there are other good reasons for having the Humanities disciplines blending with the medical sciences, but this is not to say that the humanizing effect is not to be desired. But my guess is that if we aim primarily for these other things, then the "humanizing effect" will come along by serendipity. We must presuppose only that those in humanistic studies are dedicated to exploring new areas and to searching for ways their expertise might contribute to understanding or solving human problems. Look at the total context: ideally there is a significant segment of the medical school doing scholarship in areas tangential to medicine. There are courses in the history of medicine, in the cultural and social factors of illness, and in the nature and social consequences of infectious

diseases. There are courses dealing with the doctor's role in society and his personal and professional problems, along with courses in literature where skillful writers are leading the students to feel into other emotions and situations. There are courses which analyze the ethical problems that confront the bio-medical world and courses which delve into the political and legal questions concerning health, its delivery, its decision-making, its relationship to government. In correlation conferences, along with the pathological, biological, and clinical observations, social scientists and humanists contribute their own on the family problems, the conflict of roles, the clash of value systems, or on the patterns of grief manifested in the family or the denial stages of the patient. And on and on. The point is that the whole setting is different. There is a shift in the features emphasized, the questions asked, and the factors perceived. This is not in itself "humanism," but it is the atmosphere of the relevant knowledge, awareness, and example for breeding and nurturing humanism. That atmosphere is all we can provide. The commitment is up to the individual.

B. Perspective

The "atmosphere" just described is really a matter of perspective: perspective on self, on profession, on science. This perspective is crucial and it is something humanities can help provide. By "perspective" I simply mean a point of view from which to see selected items in their many relationships to other things. And a helpful perspective would be that point of view which would initiate and sustain the attitudes and values we desire. For example, a medical student's self-image is apt to be in for hard times. He is neither scientist nor academic. Lab

technicians are better at procedures and Boy Scouts are better at first aid. Medical students must find their place and themselves: by learning more realistically their expected role, by discovering their weaknesses, and by developing their strengths. And then they must become reconciled to all of this. The influence of one's self-image on how he treats others is too well documented to belabor. And thus scholarly disciplines which give perspective on and confidence in one's self have obvious implications for "humanizing."

The compliment of disciplines we are considering would contribute greatly to this perspective. Competencies independent of medicine might be fostered leading to well-founded and much needed confidence. Focusing on other methods and other subject matter by contrast clarifies and defines the methods and concerns of medicine. By keeping other views before the student, medicine does not dominate the horizon; it takes its proper place in the landscape and fruitful interrelationships are discovered. Grasping the wider social, ethical, cultural aspects and implications of medicine enriches the practitioner's attitude, competence, and respect for himself and his calling. In short, the student discovers the uniqueness of his discipline and its similarities and relationships to other disciplines. The importance of widening the contexts for the student cannot be overemphasized. He sees science in general in its myriad dead-ends, its errors, its wrongful certainties, its ingenious victories. He sees his own profession in its historical context, in its struggle for identity, in its differentiation from other theories of man, health, and healing. He sees medicine in its ineluctable entwinement with politics, law, social context, ethics, and maybe metaphysics. He comes to see his patients within a context of family tensions, social

structures, religious commitments, and subject to deep feelings, moods, and fears. These are the perspectives that Humanities might contribute. They can be the concerns of scholarship; they can be the means for nurturing humanism. They can transform the technician. They can be the means for once again attracting excited, inquisitive, ingenious minds to medicine.

This urging might be trivialized by observing that the same "argument" would require us to institute humanities in vocational schools, police training schools, barber schools, social worker schools, and all the rest. But I find nothing in principle odd about that conclusion. It is just that inasmuch as medicine deals more directly and seriously with humans it perhaps has top priority. Besides, medicine seems the ideal arena for congregating the humanities. Here all the disciplines are centering on man. Each expertise is ferreting out what it has to say about man. Each is enhancing and challenging the other's contribution. It becomes an Institute for the Study of Man, a full study of the whole man.

C. The Format

The content and the goals of this subject matter are integrally related to methods for delivering them. That is, there are means of conveying this material and total message that are more appropriate to the material itself and to the needs of the students. I will quickly describe three points; the student situation, some suggested class arrangements, and some demands on the teacher.

(1) The dominating theme for medical students is information overkill. Every minute is jammed with absorption of facts. Schedules are packed like a plenum and academic survival hangs in the balance.

The students are exposed to endless technical details--lecture notes, textbooks, handouts, slides--all to be learned, integrated, and used. Generally this information is transferred by lectures in arena-like classrooms. Students seldom have the pleasure and confidence of having done something thoroughly. For all the information deluge, they are only scratching the surface of what is known about any given topic. This situation gives the humanities a great opportunity for startling contrast: integrating instead of accumulating, questioning instead of recording, discussions instead of lectures, depth instead of breadth, sowing instead of harvesting.

(2) These gains (by virtue of sheer content) must be incorporated in a format that best utilizes them. Discussion seems to be the key, however it can be worked out. It might be a standard seminar; it might be "Freshman seminars" dealing with exciting big ideas, meeting once a week without credit or grades; it might be "situational" teaching--consisting of several two-hour sessions with house-staff and students on a particular problem that comes up on the ward--an abortion, a terminal patient, a religious problem, etc. These approaches are contrasted to the one that is very apt to be used, namely, the large lecture course with an agenda of impressive visiting speakers and far-flung "cultural" topics. This and derivatives of this are guaranteed to keep humanities from weaving itself through the curriculum and consciousness of the medical community. Humanities will be just another specialty brought to their awareness, rather than a new perspective from which to view themselves, their profession, and their patients.

(3) Also integral to this whole scheme is the teacher's own orientation. For all I have suggested about the rich possibilities for scholarship in the medically-related humanities, the teaching is primarily

a "service." The material must be made meaningful to the student. It is a nursing function. The students' backgrounds in the humanities are uneven and diverse. The teacher must start working, wherever the student is in his thinking. A teacher might well rid himself of the notion that there can be clear-cut prerequisites and that the course's function is to build progressively on them. Requiring the student to achieve preconceived levels of scholarship seems out of place. (Such notions, of course, may be appropriate for multi-track M.D. programs or for graduate studies in the medically-oriented humanities.) But for the professional degree, teachers should be attempting to meet the needs of the students as the students and teachers together discover these needs to be. It is more putting one's own expertise to work on behalf of the students than it is delivering to them prepackaged, orderly chunks of one's discipline. It is more doing it with them than it is telling them about it. Several points about teachers and teaching relate to this emphasis:

a) Discussion is important, among other reasons, because there are no formal guarantees as to where or how far the student is in these matters. By discussion we ascertain his competencies, interests, abilities, and needs. And then we can bring to bear at the right time and at the right level the relevant aspects of our discipline. It may mean slicing it very differently from our traditional ways.

b) The teacher must be involved in the medical school world--seeing the pressures, problems, and emphases by participating in the courses, committees, and conferences. This guides him in slanting his own courses in the most helpful direction and in uncovering new areas for his own research. (This of course is more important for certain disciplines and courses than for others.)

c) An experienced teacher with fairly broad interests is much to be desired for this context. If elsewhere he has taught a variety of courses in a traditionally systematic way, he will be able to pick his way more clearly and decisively. That is, from the scattered, isolated, far-ranging clues cropping up in discussions, the teacher ideally would know what systematic structures are necessary to lead the students to understand, organize, and integrate these matters. This may require leaps across various sub-disciplines--from esthetics to philosophy of science to history of philosophy. A teacher with the various maneuvers, interrelationships, and counter-arguments at his finger tips is more apt to bring helpful order out of the initial chaos of discussion. (Whereas a beginning teacher is more like a tour-guide who must follow his own preconceived outline and has to start back at the beginning if interrupted.)

d) It is also important that our medical colleagues realize that we see our teaching as a service function, that is, as something blending with and enhancing the goals of medical education. This is in contrast to the attempt to lead students deeply into the humanities per se simply for disciplinary excellence. Such an attempt would be divisive and destructive. Humanities does not come to the medical school as "The Solution and Salvation"--it comes willing to do work in, around, and through the medical sciences to see if its own skills and knowledge might be swayed so as to contribute to the producing of a modern healer. But contrariwise, the medical sciences must realize that the Humanities disciplines are not simply service organizations, but have their own disciplinary integrity which must be pursued with single-mindedness and rigor. Just as bio-chemistry, physiology, and microbiology will siphon off from their depths those observations, structures, and skills they believe necessary

for a medical doctor, so the humanities, while remaining "academically" sound, will abstract relevant issues, insights and methods, fashioning them for their particular role in producing a medical doctor.

PART II

Philosophy in Particular

In this section I will consider philosophy's particular role in a medical setting. Mainly I will discuss three possible courses. These will not be so much course outlines as conceptual road maps. That is, I want simply to cite examples of ideas that relate to the concerns of medicine and to illustrate pursuing them to that end.

The point of this is not to teach you anything. It is to churn up your own ideas of what from your own discipline would contribute to producing our latter-day healer.

A. Overall Strategies

(1) I confess to having two very basic goals which influence all my teaching in the medical sphere. I am combating two rampant and deleterious views. One is that outside of medicine/science anyone's opinion is as good as anyone else's. All arguments are really only rhetoric. So long as you are sincere in your opinions that's all that counts. I believe this view to be quite wrong (especially in the naive sense in which students hold it) and I am at pains to lead them to experience the rigor and objectivity of extra-scientific disciplines. It is by no means merely a matter of respect; it is important for their knowing where to turn for help in certain areas, as well as knowing where they should either dig deeper or remain silent.

The second point is complementary to the first; it is the attitude of dogmatism. Not only must students see the rigor and objectivity possible outside of science, but they must be made aware of the subjective and impressionistic within science. They should gain a perspective on

the enterprise of science--its errors, its blind alleys, its fudge factors, its orthodoxies, its "certainties" which prove wrong. And the point would be to make them better doctors and scientists. Undermining dogmatism is imperative for an attentive state of mind: an openness to new clues, a readiness to reconstrue the data, and a lower threshold of significance for anomalies.

These two hidden goals guide my topics and discussion. Emphasizing the rigor available outside of science and the frequent subjectivism within compensates toward a more balanced and accurate view of the strengths and weaknesses of both. And this in turn leads students to judge the case before them on its merits--not on the company it keeps.

(2) The second overall strategy in my approach is that the courses are problem-oriented. I begin with problems that students recognize and with which they are (or could be) concerned. As we struggle over the first-level complications of the problem, some conceptual structure begins to emerge. Then conflicts and distinctions get clarified in a more general framework. Eventually maneuvers, strategies, distinctions, and conceptual networks are glimpsed, drawn out, tidied up, and criticized. This is all pursuant to a handy rubric: don't do philosophy until you're forced to.

There are good reasons for having the course problem-oriented (providing of course the material admits of this approach). One reason is simply that given the variety of backgrounds and skills of the students, problems make a good common-ground beginning. Then, too, these students are problem-oriented to begin with. Clearly seen problems motivate them. They are not accustomed to responding to abstract ideas per se. Neat points and subtle contradictions do not excite them--or, if at all, only

when something of a more practical nature pivots on them.

Also the entire atmosphere conduces to a "problem" approach. The students' extreme busyness and harried struggle for survival inevitably focuses them on whatever has relevance to their profession. And a problem stated in everyday language strikes them as relevant and challenging. And once into it, they are much more patient and appreciative of the conceptual machinery with which they may have to become familiar in order to deal with the problem. Undoubtedly this is not the most efficent way to teach a course, but the students gain and retain much more.

(3) The last point of overall strategy is my emphasis on developing a skill rather than accumulating more information or simply becoming aware. This may be nothing more than an emphasis, but it seems important enough to try. One wants the student to develop a "feel" for raising the right question, for ferreting out the real argument, for locating the pivotal point. He should gain a "sensitivity" for detecting the assumptions and the implications of various claims and policies. Conceptual machinery must be kept at a minimum, as should the sheer information about philosophy, its variety of positions on any matter, and its endless subtleties. Legal scholarship makes a good model: it manifests all the nice distinctions and clever maneuvers; it ingeniously garners principles, arguments, and evidence. It does this for a practical end; it must reach a decision on a problematic matter. Perhaps this is more the slant we should give to philosophy within a medical school.

B. Ethics and Medicine

This section and the rest of the paper will be concerned with specific philosophy courses molded to conform more to the needs of the

medical world. Outlines, bibliographies, and requirements are not now to the point. I want rather to sample the mixture of theoretical and practical--perhaps mostly to convince philosophers that there can be stimulation even in being practical.

There are many standard problems in "medicine and ethics" from which to choose: abortion, euthanasia, selection for limited life-saving therapy, value imposition (in medicine), biological engineering, civil disobedience (with respect to medicine), obligations and duties, etc. As the students begin with these problems I gradually introduce relevant distinctions and concepts in order to break deadlocks or resolve conflicts. Sometimes we are forced to concentrate on these concepts and distinctions themselves, thereby being lead still deeper into the conceptual network. As the course continues, I try to keep this emerging theoretical structure before them; we appeal to it and revise it in dealing with subsequent problems.

Again, the "service function" predominates. I am not trying to lead them to certain preconceived levels of "scholarship;" I am attempting to seduce the students into critically examining their own beliefs, feelings, and value commitments. Their own contradictions, ambiguities, and confusions are flushed from the underbrush and focused upon. By this point they are actively seeking conceptual help.

Perhaps it would be a help to see an example of the succession of issues released by prying into a problem. For example: Abortion. Is fetal life human? This raises questions of how things get defined. Is definition something "in the nature of things" or is it entirely arbitrary? Or perhaps a bit of each wherein human purposes or arbitrary goals influence certain definitions? But in the zygote-fetal-infant-child

continuum is there a "break" sufficient to justify the "human"/"non-human" distinction? Can the continuum be stretched back to the sperm or maybe even to the beginning of all life? Or is that a confusion?

But isn't it "ordained by nature" that procreation is for producing progeny, the likes of which ought not to be interefered with? What can be meant by "natural law?" Various views and refutations are examined.

Is the concept of "person" any help? What is it? Surely it would not apply to an infant, let alone a fetus. In fact when is "personhood" attained? Perhaps it could be a help in the euthanasia problem, but not with respect to the beginning of life.

What is a "right to life?" What are "rights?" Can a fetus have them? Perhaps there is a clear answer in law. But law is not morality. How do they differ? Do not "rights" presuppose an ideal form of society? Can there be objective criteria for such a thing? If not, can we speak meaningfully of "rights" at all?

Abortion is likely in accord with "least suffering." But is it "just?" How are "justice" and "least suffering" distinguished? But can "ultimate principles" conflict? What does one do then?

Does "Sanctity of Life" give us direction? What is it? A feeling? A command? A quality of life? A general orientation? A religious belief? But what is the relation between religion and morality? Does "Sanctity of Life" tell us whose or what kind or in what circumstances life is to be preserved? Answering this might lead to reasons for and reasons against, and this in turn to the concept of "reasons-on-balance," and so on.

Probing this problem would have produced some initial inroads into an ethical framework. Some basic distinctions between law, religion,

and morality emerged. Talk of "ultimate principles" would have elicited some discussion on the structure of moral arguments, and something on cognitive vs. non-cognitive ethics. This move would raise consideration of moral relativism, touch on the foundation of ethics, and lead to the question "why ought I be moral?" And as other medical-ethical problems came due for discussion these forays into ethical theory would be deepened and widened. "Rationality and ethics," "'guide to life' vs. morality," "moral ideals vs. moral obligation," "universalization," "concepts of rules" are further issues which inevitably crystallize out of discussion.

Meanwhile their "slogan" approach to medical ethics is breaking up. "Two deaths are better than one murder" (concerning abortion in the case of a life-endangered mother) "Prolong living, not dying," "Ordinary means vs. extraordinary means," "All life is sacred," "Withholding therapy vs. putting to death." These and others come out sooner or later for careful scrutiny.

Before turning to other courses, consider another sample problem from medical ethics--this time more briefly. This is the issue of "value imposition," which appears a bit remote from medicine. A good beginning would be Szasz's posing of the problem with respect to psychiatry. It is not particularly subtle and it provokes involvement. What gets labeled "mental illness?" Deviation from a norm. But whence the norm? Is it an "objective" criterion? Or has a value argument infiltrated? Is there a difference? Or is an "objective criterion" simply a value judgment generally accepted? If so, what justification would there be for acceptance of the value judgment? Is the "illness" model then appropriate to non-organic mental syndromes? What is to be gained or lost by using this model?

But isn't physical health also measured over against a norm?

Then that also must be a value judgment. How do we justify that? And more generally, are value judgments inevitable in science? What kind? Where? Why?

All of this raises the standard philosophical topic of facts and values so as to be relevant to the student's concerns. They begin to see the "logic" of facts and values and how they might really be the same thing. And these may get distinguished from "personal taste" which would appear more dangerous in its subtle infiltrations. Where criteria for judgments and labels are vague, one comes to be on the alert for unwitting inclusion of personal tastes. One comes to see the basic distinction between the judgment that something measures up to a certain criterion and the justification for that criterion. He sees the difference between an argument to classify in a certain way and an argument concerning the facts of the case. And so on.

Of course none of these "humanities type" probes will initially produce commitment and motivation. However, for example, if a student is already anxious not to impose surreptitiously his values on others, then these discussions will very much sensitize him to the subtle ways it can happen and enable him to work his way through the maze of claims, counterclaims, values, facts, and tastes to a fairer, more explicit means of doing his job. This must be "humanizing" in an important way. (For further examples of theoretical strands unravelable from practical concerns, see Appendix A.)

C. An Interdiscliplinary Effort

What follows is an abbreviated description of an attempt to embody some philosophy of mind and philosophy of science in an ostensibly medically-relevant course. I teach it with a psychologist and we call

it "Theories of Personality: A Psychological Description and a Philosophical Critique." My hidden goal is to bring the students to a perspective on theories and established views wherein they freely and responsibly criticize these deliverances. Again, this is done in hopes of breaking down their incipient dogmatism. Hopefully they will come to appreciate the human factor in all these conceptual constructions and will consequently remain open to new influences and clues.

Presumably the course purpose is to become familiar with several theories of personality, namely, the Freudian, neo-Freudian, existential and behavioral theories. Readings and case studies dealing with these theories are assigned, and class discussion is focused on the theories. The philosophical issues are left to chance, but invariably they begin taking over. As students come to the point of questioning these theories--an issue forced by the sheer juxtaposition of competing theories--I attempt to elicit from them further, more critical, more articulate formulations of these first-level misgivings. As these considerations take form, readings in "straight" philosophy of science or philosophy of mind are assigned. By then the students see the point of and are eager to read the philosophical literature.

It is not hard to imagine the philosophical issues which would bubble to the surface in these psychological works. But perhaps another staccato account of the possible sequence of events would help. Not long into Freud's "theory" the students begin puzzling over what it is to be a theory. It somehow seems different to them from those they have encountered in physics and chemistry. We narrow in on the nature of theories, their logical structure, the role of axioms and of evidence. This quickly brings "laws" under surveillance. "Prediction" and "explanation" come

up in this context (wondering if Freud has "really explained" anything, especially if he still cannot predict). The seeming malleability of all phenomena to Freud's theory is soon set upon and eventually we hammer out a clearer articulation of "non-falsifiability." The obvious "hydraulics" of Freudian theory provokes discussion of the role of models and how they might or might not differ from theories, or whether or not they are simply illustrative. "The Unconscious" perhaps heads the list of troubling concepts, and we are soon compelled to deal explicitly with theoretical entities and the accompanying network of related concepts. This all ties in nicely with our earlier discussion of theories and may be an opening for discussion of "theory-laden" observations and "the given."

The other theories raise some of the same points and some new ones. Existential psychotherapy always demands discussion of the freedom-determinism issue and its subtle components concerning predictability of human actions. In the context of existentialism, the concept of "rationality" may come in for its share of attention, together with the question whether the possibility of psychoanalytic explanation for every action doesn't thereby make all actions rational. This in turn may elicit attempts to distinguish "reasons" and "causes."

Similarly behaviorism can be counted on to drag out many philosophical ploys. The ghost-in-the-machine and its related constellation of comments, puzzles, and explications are called forth. "Motives," "intentions," "abilities," "dispositions," "feelings," and "emotions" might in this context get distinguished and explicated, insofar as certain preconceived notions of these terms may be what is winning the day for one of these theories over another. That is to say, we aim not to multiply philosophical distinctions, points, and puzzles beyond necessity.

The rule-of-thumb is that they are admissible only insofar as they are necessary for understanding, criticizing, or comparing the theories of personality in question.

The nice feature is that all these points are instigated by students as they struggle with material they believe to be professionally relevant. Mine is the old and forgotten philosophical role--the maieutic function. The students don't indulge in pholosophy until compelled by the conceptual maze of the subject matter. And meanwhile they are fulfilling their basic aim, namely, learning and understanding several influential theories of personality.

D. A Vague Course Proposal: Philosophy of Medicine

This miscellaneous gathering of topics could conceivably comprise a course. I've presented bits and pieces here and there in other people's courses. It would be an attempt to bend the philosophy of science toward medicine. For awhile it would have to be honestly titled "A Philosophy of Science on Its Way to Becoming a Philosophy of Medicine." It would generally consist of standard philosophy of science issues being carried out on medically-related concerns, until issues and rationales more indigenous to medicine emerge. At that point it might become more distinctively a philosophy of medicine course. To elaborate on this notion I will simply list some of the issues that might prove valuable--this time making no attempt to suggest their sequence and interrelationship.

(i) art vs. science: This is an old issue, but it may have special importance for medicine, where art and science are popularly thought to blend. Explicit and rigorous attention to this issue could be very fruitful. Consideration of "intuition" and "tacit knowledge" would be included.

(ii) the logic of discovery: This would be a natural outgrowth of discussing art vs. science. It could profitably consider the psychologic of discovery as well. Discussion of the philosophical problems of observation (e.g., theory-laden observation) would be particularly helpful in the medical sphere.

(iii) explanation: A philosopher need only hear the word "Molière" to concur that explication of this concept is much needed in the medical community! "Explanation" is frequently used.

(iv) probability: Some philosophical overview on this could be crucial. Probabilities and statistical proofs are much relied on in medicine and frequently probabilities are starkly cited to patients who are trying to decide on alternative therapies or procedures. Various risks are stated in terms of probabilities.

(v) teleology: This and all the related concepts seem to be of great interest to medical students--purposefulness, causes and reasons, determinism and freedom, willing, mind and body.

(vi) reduction: Related to the preceding item, the points and counterpoints of the possibility of reducing all phenomena to a biochemical base intrigue students. Students seem quick to assume one or the other position, but totally without a clue as to what an argument for or against it would look like.

(vii) philosophy of biology: The "Species Problem," interpretations of evolution, including some metaphysical views.

(viii) concep of disease: A consideration of various views of disease--essentialist, substantive, functional, etc. and of how these views guided research; how particular assumptions about disease provoked certain lines of questioning and not others.

(ix) causation: Medicine is a science which still unabashedly

talks about "causes." Having a perspective on the concept would give considerable help. For example, clarification on such issues as our selecting "the cause" from among many causes, or on "causal mechanisms" being at bottom only "regular sequence," or "simple correlation" and "causal relation" being so vastly different.

(x) facts/theories/laws/observation: Issues of falsification, conventionalism, and theory-laden words and observations would seem particularly enlightening for the medical world.

(xi) Kuhn's thesis: It would be highly informative and profitable to look for the guiding paradigms and for the circularity of theory and evidence in the clinical sciences.

(xii) science and value: Are value judgments an unavoidable part of science? Of clinical science? What determines on whom the "burden of proof" should fall, e.g., in public health matters.

(xiii) philosophies of medicine: A study of the metaphysical assumptions and connected beliefs in witchcraft, faith healing, Christian Scientistism, chiropractic, osteopathy, and homeopathy. By studying apparently contrasting theories one could gain important insights into his own brand of medicine. In trying to argue that chiropractic is not a science or that it has no "scientific method" or that it is not integrated with other sciences, a student will learn a lot about the debits and credits of his own "science." And his spotting the more obvious metaphysics in an "unorthodox" therapy theory may very well lead him to discover the metaphysics underlying his own theory.

In addition to fulfilling my goals of perspective and antidogmatism, this course could conceivably go a step further. It could give an exciting intellectual or conceptual framework to medicine, as

contrasted to the recipe appearance it has to most of its practitioners. This would not only hold innate interest, but it would create a sense of professional identity and, correlatively, a stronger self-image.

E. Et Cetera

1. Still other courses.

I am aware that what I have said may seem to presuppose a certain metaphilosophical commitment, namely, one stressing conceptual analysis. But I would not want to limit philosophy to this handmaiden role. Mainly two facts swayed me in this direction. It was the approach I understood best. And because of the students' extreme busyness and their pre-occupation with their trade and their survival therein, I emphasized the "service" function. That is, I tried to achieve my goals for them, but I did it by helping them do what seemed to them most congruous and relevant.

But other views of philosophy might well work. For example, one can easily imagine the phenomenological method tying in with some medical courses and psychiatric courses. Insofar as the medical school becomes more an Institution for the Study of Man, phenomenology with its skills and sensitivity focusing inward on man would be highly appropriate. A metaphysical type could give a course in "Concepts of Man," which would blend very helpfully with other views of man the students receive explicitly and implicitly. A literarily inclined philosopher might give a course in philosophies of life, whose contribution would be more on the level of personal help to the student. In short, the possibilities for other courses, emphases, and contributions are probably extensive.

2. Other Formats

As a parting shot I am imparting another list. These are standard philosophical topics which relate nicely to standard medical

topics, to the benefit of both. These are perhaps most effectively done within the appropriate medical course, that is, as a one-shot "intrusion" into that course (a phenomenon I have disparagingly labeled "the-jack-in-the-box performance," where in the midst of a serious, sustained science course a happy humanist briskly and abruptly pops up for a word or two.) But any of these topics would be good for an afternoon panel discussion, a weekend conference, or a joint seminar.

(i) histology: The patterns-of-discovery theme and theory-laden observation are appropriate reflections as one begins to study the new world of microscopic anatomy.

(ii) brain physiology: The concepts of memory, of action, of pleasure, and of pain could all profitably be raised in the context of brain physiology (or perhaps in neuroanatomy). These now are left out entirely--much to the detriment of both disciplines and some conceptual excitement. Also I suspect that a philosopher of language could contribute to studies in "brain function and language." For example, his sensitivity to language's nuances, differences, structures, etc. could be an important guide to the geography and function of the brain.

(iii) neuroanatomy: The obvious topic for this is the mind-body problem. And the "identity theory" in particular would be of interest since it is the one most likely to be subscribed to (however unknowingly). Neuroanatomists have asked for this, and students also can be intrigued. (One time I assigned articles by Adrian, Sherrington, and Eccles. Students thought these men were philosophers and criticized them vehemently for their sloppy speculations about souls and minds. Upon learning that these authors were really neurologists, the students were hooked on the issue and avidly pursued some clarity in the matter!)

(iv) psychiatry (or psychology): perception; creativity; rationality; emotions; belief and knowledge; value or belief "systems." All these have been richly pursued in both disciplines; it seems high time they talk and listen to each other once again.

F. What's in It for Philosophy?

Presumably any discipline might ask the same question. And presumably an answer very similar to philosophy's might be given. An adequate answer obviously demands considerable discussion. Here I can only sketch a reply.

(1) Philosophy can for the most part continue to do and be what it has been. For teaching purposes, of course, it is asked to peel off those features of itself which would enhance the end product of a medical school. Its job is not to turn out philosophers but healers. However, in doing its own traditional esoteric job well, it will be all the more able to relate rigorously and creatively to its new context. Doing "straight" philosophy and using philosophy in medical school courses are two very different things. But the latter certainly depends on the former being done well.

(2) New avenues of research open up in this area of overlap. They are by no means completely new, but the emphasis, the slant, is new and holds promise of interesting new insights. It is not unlike philosophy's turning its attention to physics, mathematics, education, religion, etc. Much of philosophy's "basic equipment" is used in these forays, yet new insights are gained, new problems isolated, new tools developed. Philosophers are beginning to prowl around psychiatry and biology, which is a good thrust in the medical direction. And there is some reason to

think that there is still more to be mined by continuing the advance into medicine itself--its institutions, its ethical problems, its sciences. (See Appendix B for an example.)

(3) A close working relationship to "factual" disciplines would be advantageous to philosophy. Philosophy's relationship to facts is as mysterious as value's relationship to facts, but at least facts seem to be the sine qua non of both philosophy and value. A working involvement with factually-oriented disciplines helps the philosopher sharpen his problem, articulate and document points, use revelant illustrative material, avoid gross factual errors, and maintain a steady supply of factual fodder on which philosophy finally feeds.

This paper has been primarily an effort to state and have done with the obvious, as a point of departure for discussion. I have considered the direction and rationale of a medically-based Humanities Department, the various teaching formats and needs, and the emphases which might prove successful. By describing some of philosophy's attempts, I had hoped by sympathetic vibrations to bestir you to think of aspects of your own discipline which could profitably mingle with the medical world. Along with some explicit assurances that you would probably not unduly compromise your disciplinary purity, I was attempting in, under, and through the text to lure you into professional involvement.

K. Danner Clouser
Department of Humanities
College of Medicine
The Milton S. Hershey Medical Center
The Pennsylvania State University
Hershey, Pennsylvania 17033

APPENDIX A

Topic	Some Issues Involved
Abortion	natural law, morality vs. law vs. religion, "sanctity of life," concept of person, right to life, reasons-on-balance, "quality vs. quantity" (of life)
Euthanasia	duties to self, "taking life vs. letting die," "ordinary vs. extraordinary means," "human rights, self-identity, concept of person," "wedge arguments"
Human Experimentation	consent, rights, least suffering vs. justice
Selection for Lifesaving Therapy	justice, randomness vs. rationality, facts and value, worth/worthiness/worthwhileness (of a life), reward vs. future promise (as social criterion)
Value Imposition (in medicine)	problems of definition and classification, facts and values: distinct? related? identical? are value judgments inevitable in science? verifying vs. validating, personal tastes vs. value judgments
Biological Engineering	existence of a "human nature," essential vs. existential, promoting good vs. preventing evil, positive eugenics vs. negative eugenics, justifying obligations to the future, coercion vs. incentive
Obligations of the Physician	a moral rule? justice, rights, contracts, promises, morality of striking

APPENDIX A - continued

Topic	Some Issues Involved
Civil Disobedience (and the Physician)	ethical justification, legal issues, conscience vs. law, conscience and morality, confidentiality, justice, rights
Ethics	moral relativism, "why ought I be moral?" "guides to life" vs. morality, utilitarianism vs. morality, rationality and morality, moral ideals vs. moral obligations, structure of moral argument, cognitive vs. non-cognitive ethics, vs. ought

APPENDIX B

I will briefly speak to the toughest objection to philosophy's involvement in medical education. My guess is that a philosopher's greatest sistance would be to the idea of "applied philosophy." This would be felt to be a dead end, a perversion, the lower road. Whereas most philosophers might readily acknowledge the possible fruitfulness (for philosophy, anyway) of intellectually mingling with other disciplines, "applied philosophy"--whatever it is--would be felt to miss the point of what philosophy is all about.

For the most part I would not want to argue with that position, but only tone it down. I would contend that practical investment may yield conceptual returns. The yield may not be high, but it's there. It shouldn't be too surprising that confrontation with practical matters would occasionally show a theoretical concern to be wrong, or inadequate, or misleading.

Let two examples suffice: an example of a "practical" orientation eventuating in a matter of some conceptual interest and the other, an example of "practical" ethical problems uncovering an inadequacy in the "theoretical."

(1) Ethics has explored in some depth the concept of obligation and in some cases has investigated and justified the moral rule "do your duty." Now, in this context, an additional task might be done: delineating what that duty is (for doctors), how it might be justified, when exceptions can be made, where rights must be weighed, etc. And it is not clear that this is any less a philosophical challenge than explicating and justifying "obligation" and "duty" in general. And it might well uncover problems, answers, and surprises missed by the more general

considerations.

(2) (a) The abortion issue raises interesting challenges to some of philosophy's maneuvers. For example, the criterion of "reversibility" (i.e., imaginatively putting yourself in the other's place) makes no sense at all in this case. We cannot imagine being a fetus and we have absolutely no fear of becoming one. Does this then mean that "an ethical relationship to a fetus" is meaningless? Also, the criterion of "least suffering" is not very helpful with respect to the fetus. Because it doesn't suffer can it be ignored? This line of questioning gains added push from another "practical" realm. Why does the sudden death of a young, talented person strike us as a tragedy? There may be no suffering involved. Rather it seems to involve loss of "potentiality." "Least suffering," "justice," "liberty" (commonly regarded "ultimates") do not seem to be at issue. Perhaps "potentiality" has been a hidden criterion we should pay more explicit attention to in ethical reflections.

(b) Similarly, we might sense an inadequacy in the usual ultimates of "least suffering," "justice" and "liberty" when we consider our husbanding of natural resources. Have we an obligation to the future? If there were no people and no resources would we have transgressed least suffering, justice or liberty? On the surface it would seem not. Then whence our sense of obligation to the future?

(c) Most theories of ethics purportedly founded on "rationality" have concern for one's self and his friends as the "backbone" to ethics. Does this relieve us of moral obligation to fetuses, the congenitally defective, or future generations, since it is totally impossible for any of us ever "to be in their shoes?" That is, we are totally safe from

any kind of retributive action.

This is by no means to say these questions cannot be handled within standard frameworks of ethics, but it is only illustrative of the kind of serious challenge which practical involvement can bring.

SUMMARIES AND SYNTHESES

OF GROUP DISCUSSIONS

1. Physician-members of the group were able to identify a number of behaviors and attitudes that are desirable in medical students and practicing physicians, but that present medical education seems to have difficulty producing. They felt that certain deficiencies in medical education could be remedied more effectively by humanist-teachers than by physician-teachers.

Over-emphasis on the rational and objective

Medical education stresses rational, objective thinking so much that the student gradually loses both his inclination and ability for introspection. As he loses touch with his own feelings, it becomes increasingly difficult for him to remain aware of patients' feelings and respond to them appropriately. As this analytical habit of mind develops, the student's sensitivity to subjective aspects of clinical situations diminishes, and frequently he does not examine adequately the ambiguities and potential consequences of certain decisions because he does not perceive that they are present.

Humanities studies, it seems, can provide contrasting experience in abstract, theoretical thinking, not simply to preserve but to heighten and refine this quality of mind. Such studies can also supplement the student's own experience at being a human, feeling person by acquainting him with relevant life experiences of others. Michael Novak, one of several philosophers present who discussed the implications of medical students' personal experiences, pointed out that all students need help in viewing critically their own experience, and especially in assessing both the validity and the limitations of that experience.

One of Joe Tupin's observations was that "to be a whole man includes being rational. But there is a time for a surgeon to be a technician, and a time for him to be an emotional human being." Other

physicians seemed to share Dr. Tupin's feeling that current medical education offers little to help the student develop a discriminating instinct for different situations that require different responses from him. Perhaps humanists can help medical students cultivate the important skill of observing correctly and behaving appropriately.

Uncertainty about values

Values are at the core of many difficult decisions that must be made in the practice of medicine, but medical education has not developed effective ways of teaching about values. Bernard Towers posed the problem succinctly: "We need training that produces physicians who can make 'right' decisions when what is technically feasible conflicts with what is humanly desirable."

To identify "what is humanly desirable" requires a knowledge of human values that seems not yet developed on a societal scale. Dr. Towers added, "Society itself has not yet thought through what it wants in regard to issues such as extraordinary prolongation of life, resuscitation, consent to end one's own life, euthanasia, as distinct from what has been called orthothanasia, etc."

In Lee Cluff's view, the individual physician shares the layman's uncertainty about guidelines for decisions involving human values. He knows quite clearly how much in control of events he can be because of what science and technology now make available to him; he is aware of the range and degree of choice he has. But he lacks--and urgently seeks--bases and rationales for choices.

Compounding this difficult matter of values is a fact pointed out by Carroll Rosenberg, an historian, and attested to often during the

conference by physicians who referred repeatedly to the "new breed" of medical students. To paraphrase Dr. Rosenberg, new values are in the air now, and in many instances students entering medical school have already assimilated them, and wish to act within newly defined boundaries that their teachers have not yet come to grips with.

The humanistic tradition includes a number of well developed (truly "time-tested") ways of examining the values of the past for their own sake, and also for their ability to illuminate the present and suggest the future. To the extent that humanities studies can offer medical students both experience in recognizing value-laden issues and methods for appraising value-laden situations, they could be helpful.

No humanistic discipline can teach "right" values, but many centuries of thought are available to assist in the difficult and crucial task of developing awareness of the great range of differing value schemes so that one can learn the difference between one's own and others', together with the significance of that difference. The hope for assistance in this area was expressed by Dr. Pellegrino this way: "The humanist is not automatically able to handle these matters, but at least he comes out of a tradition that addresses them."

Avoidance of moral-ethical confrontations

The humanistic tradition appealed to by Dr. Pellegrino includes centuries of speculation about moral and ethical issues, and this resource is attractive to physicians who are eager for help in dealing with the moral and ethical questions that modern medicine raises more and more frequently and urgently. There seems to be a role for the humanist when life-and-death decisions must be made, and he seems to be desired as an active participant, not merely as a commentator.

Joe Tupin addressed the question of medicine's morality by observing that in general, physicians are not honest about identifying life-and-death decisions. Far from making them openly, they hide behind the standard posture that the prolongation of life as long as possible is the culmination of a long and honorable tradition that should simply be continued. The explicit question of whether or not this view is correct is not asked, Dr. Tupin asserted. George Wolfe agreed: "Our taking the amoral position that this is not a moral decision, is itself immoral." In his opinion, humanists can be uniquely helpful in this difficult area by asking the physician the basic question he does not ask himself: "What are you doing, and why?"

A personal experience recounted by Louis Lasagna illustrates this discussion vividly. While reviewing reports of the deaths of three patients, he was struck by the great similarity of facts about each one--age, socio-economic status, disease, course of illness, length of hospitalization, etc. When their conditions became critical, however, they were treated quite dissimilarly. No effort at resuscitation was made with one patient; resuscitation was attempted for about one hour with the second; and resuscitation efforts continued for approximately three hours with the third.

Wondering why the response was so varied, Dr. Lasagna called together the residents in charge of the respective patients, and discovered that none had any particular rationale for the degree of effort he had or had not made. None had thought about his decision before, during, or after making it. Dr. Lasagna also learned that in the entire course of their medical education, these residents had neither received formal instruction in, nor participated in informal discussion about, the relation between the act of resuscitation and the variables that form a

context for the act.

Inadequate teaching of communication skills

Despite the obvious importance of clear communications between doctors and their patients, fundamental communication skills receive little attention in medical school. Medical students who write, speak, and listen poorly are criticized for these deficiencies, but are seldom helped to become better communicators. Since clear thinking must precede clear communication, methods of logic and causal reasoning must be understood and practiced--indeed, insisted upon.

While a literal return to the old trivium is probably not the best way to teach grammar, rhetoric, and logic to medical students, these fundamentals of communication can be taught through deliberate focus on the literary aspects of the humanistic tradition. Even listening and hearing can be given new perspective if they are examined in the context of certain works of modern fiction, for example, that portray the dilemma of the speaker who is not heard.

Restricted, incomplete view of physician's role

As a whole, medical education has been unresponsive to the totality of changes that have occurred in the past few decades, and has failed to change itself accordingly. It continues to train physicians for a role that is too narrowly and unrealistically conceived. Medical schools foster in their students the expectation that their future work will consist primarily of solving medical problems whose solution will require primarily medical knowledge.

Yet many common contemporary problems presented to the physician are only minimally medical, and he is not trained to handle the non-medical considerations that require major attention when he is asked to set up a neighborhood health center, initiate birth control programs, determine priorities for use of kidney machines, formulate policies for abortions and organ transplants, define the role of the physician's assistant, etc.

These examples were cited by Dr. Lasagna as he expressed his hope that humanities studies could help doctors see that their contemporary role is broader than the old-style one-to-one relationship between the patient and the doctor. Now they must relate to the total community, and medical education must help prepare them for this by changing itself to include the new societal thrusts.

David Musto added to this discussion his observation that although most medical students seem keenly aware that doctors are now viewed ambivalently by the public, many practicing physicians are unaware of current criticism of their profession. Dr. Musto believes that outsiders can be more effective than insiders in helping these doctors learn that their position in society has changed, and in explaining to them the reasons for the public's hostility and resentment. These isolated physicians, Dr. Musto noted, can be found in large numbers in county and state medical societies, which he regards as an audience that needs insights from humanists as much as medical schools do. Here Dr. Pellegrino concurred emphatically, and added his hope that eventually humanists will become involved in all programs of continuing education for physicians.

2. The candor with which the representatives of medicine revealed the weaknesses of current medical education and practice was matched by the willingness of humanists to cite the imperfections of their disciplines, also, both now and historically. Perhaps so that physicians will not hold unrealistic expectations of the humanities, a number of humanists discussed various shortcomings of professional humanism.

Humanism's negativism toward science

"A very old antipathy" toward science was described by Lynn White as he cautioned that myopic humanists cannot help medicine--and indeed, in many instances, do not wish to. There is a regrettable but real tradition among humanists of contempt for basic science and hostility toward its application, despite the fact that most humanists know extremely little about the nature of science, and choose to remain ignorant of it.

A number of other humanists concerned about this same provincialism spoke of humanism's continuous difficulties in relating satisfactorily to the rise of science, especially as the scientific "method" with its "techniques" impinged increasingly upon humanistic studies. Max Black noted some specific characteristics of the scientific method that are antithetical to traditional humanistic approaches, such as repression of personal human response; cultivation of respect for objectivity; conscious pursuit of detachment; and notation of facts and data.

Humanism's own over-specialization

One consequence of the scientific method's influence on humanism has been the emergence of specialists in small areas of the humanities. These individuals have become masters of such narrow fields that they are esoteric as well as expert. If highly specialized scientists are to be criticized because they are too remote to be effective teachers,

the same charge must be made against specialized humanists. Both groups have little of general import to say to students.

3. Personal and professional relations between physicians and humanists were discussed at some length, and it became clear that critical issues lie here.* Resolving them--or at the very least, recognizing their existence--is the indispensable preliminary to recruiting humanists to teach in medical settings. As Al Vastyan pointed out, "Humanists are not exactly breaking down the doors to teach in medical schools."

Professions vis-à-vis each other

Speaking as recorder for his group, Ruel Tyson acknowledged that the problem of any two professions' enriching each other is very great, and when professions are as different from each other as medicine and the humanities, the degree of difference only deepens the problem. Noting that the two have different views of nature, he suggested that perhaps this philosophical divergence accounts for their different attitudes toward technology and applied science.

In any case, both humanists and physicians seem to accept the generalization that humanists are interested principally in ideas and theories, and physicians in people and deeds. Further separations occur as the differing content of these disciplines fosters differing styles of thought which eventually become set in what Dr. Tyson characterized as "guild mentalities." Constricted by their respective modes of thinking, both professions tend to perceive each other stereotypically and to harbor unexamined assumptions that are never discussed with each other.

*The same issues emerged with the same urgency and clarity during Lorraine Hunt's survey described on page one of this document. Excerpts from her final report to the National Endowment for the Humanities are attached as an addendum to the Institute's discussion of this matter.

The humanist as outsider

David Musto's report as recorder emphasized the importance of realizing that humanists and physicians have had very different life experience, but "neither side appreciates the other's cultural baggage." It is inevitable that one will be uncomfortable if he moves into the other's arena, and confused when he encounters situations in which certain apparent complexities have been tacitly over-simplified by the insiders.

The humanist who has never made ward rounds and has only a layman's familiarity with the clinical setting feels alien, and quickly moves from feeling like an inferior outsider to feeling angry at being put in such a position. At this juncture having a group of humanists rather than a lone individual could be critical to the continuation of a cooperative effort between medicine and the humanities, for the psychological lift of the "critical mass" could avert the development of professional anomie on the part of the humanists.

Autonomy for humanists

Tom Altizer seemed to articulate the reservations of some humanists present when he wondered whether medicine was prepared to allow autonomy to the humanist in a medical setting, or whether his potential contributions would be received only as ancillary to the work and concerns of the physician.

Other discussants added the caveat that the speculative concerns of the humanist are antithetical to the task orientation of the physician, and that both sides will be disappointed if one expects to convert the other to its own point of view, style of thinking, and definition of work.

4. Discussion of the contributions that the humanities might make to medical education included advice about approaches, structures, and attitudes that have maximum likelihood of success. Not recommended was the standard "course" presentation, a matter expertly covered by Dan Clouser (See pp. 47-80).

Limitations of the elective approach

Additional reasons for not relying on courses were mentioned by Fuller Torrey, who pointed out that medical education is moving rapidly away from the notion that medicine is best learned by taking a succession of courses in a pattern prescribed for all students by the curriculum committee. Courses that have been traditionally required are becoming optional, and in all medical schools there is more and more opportunity for elective study. Thus to "require" medical students to study humanities would be to go counter to the present movement away from a prescribed curriculum.

Commenting further on elective study, Dr. Torrey noted that giving medical students time to elect humanities courses in other departments of the university does not have the outcome some people may wish for. Making these courses available is not the same as making them meaningful, and what makes them meaningful to medical students is a problem-oriented medical context that they can respond to out of their immediate experience.

For example, The Death of Ivan Ilyich has much to teach a medical student, and he will read it attentively if it is part of a course called "Death and Dying" that has the approval of the medical faculty and is taught by a credible person--someone (not necessarily a physician) who has encountered death and dying firsthand and repeatedly in the medical setting.

The same book may be included among the readings for a course

offered by the Comparative Literature Department under the title "Late Nineteenth Century Russian Fiction," and the course may be superbly taught by a professor who has great skill in making this book an insightful vicarious experience of death and dying. But it is unlikely that a medical student would even think about electing a course that seemed so remote from medicine.

Importance of relevant context

Dr. Torrey's emphasis on the importance of context was reiterated by nearly half a dozen members of various discussion groups who pointed to the mistakes made repeatedly by teachers of courses in the history of medicine. These courses are seldom successful because they are taught as antiquarian studies in the context of yesteryear, and are perceived by medical students as having nothing to do with today. In addition to seeming like "a disconnected series of vignettes about the lives of great men," as Dr. Pellegrino described them, these courses do not deal with the patient-centered problems that medical students are interested in solving.

Yet as David Musto pointed out, this need not and should not be the case. The history of medicine provides subject matter for teaching medical students important lessons about using the past to understand the present and anticipate the future. It is possible to show, for example, that certain kinds of legislation now pending at state and federal levels are the direct consequences of past events in medicine, but there will be future consequences, too. Medical students' intense concern with contemporary issues makes them all the more accessible to any teacher who can relate the contemporary and the historical.

Structure for humanists' teaching

Two suggestions recurred in discussions about the kind of situation that might be created to enable the humanist to contribute to both medical education and practice.

There was considerable support for the case-study method as probably the best model for the humanist to follow initially, at least. It involves a mode of thinking that medical students are comfortable with, and it offers a way of attracting their interest until the subject matter begins to generate some intrinsic interest.

This clinical approach was recommended also as a way for humanists to participate in patient care. It was suggested that a humanist be included among the medical personnel who do patient work-ups, giving him a full voice in raising questions about the patient's total situation, and making recommendations about plans for his care and ultimate disposition. Included in this suggestion was endorsement of the spreading practice of asking non-physicians (some of whom presumably are or may be humanists) to serve as citizen members of boards that make decisions about organ transplants, abortions, deployment of kidney machines, etc.

5. In discussions about the intent and content of premedical education, most physicians did not view the undergraduate years as the time for providing students with a humanities background that will carry over and have relevance to medical education.

Premed majors aim at medical school

The undergraduate who knows that he wants to become a doctor typically shapes his entire undergraduate education according to his notion of what will enhance his chances of being accepted into a medical school. Sometimes because he is so advised and sometimes

because of his own inclinations, he tends to pursue a narrow and heavily scientific premedical course. At this point in his education, the typical premedical major simply is not interested in the humanities, either for their own sake or for any relevance to medicine that they may have.

It is important to remember that if current science requirements for premedical majors are altered in the future, it will be necessary to restructure existing courses in the basic medical sciences, all of which now assume a reasonable grasp of the physical and biological sciences.

Dr. Towers described an experimental program at UCLA that might be evaluated for its usefulness to premedical education. It is called the "Professional Competence Core: An Interdisciplinary Curriculum for Undergraduates." Dr. Towers explained that this proposal was initiated by seven of the graduate professional schools at UCLA "as a means of teaching prospective members how to think. Although the Medical School was not one of the seven concerned, yet I am pretty sure that once we see what the course can do for students, we will prefer it to some of the other standard 'premedical' courses."

Relation of humanities to medicine needs demonstration

For many humanists and physicians as well as for many students in both fields, the relevance of the humanities to medicine is not self-apparent, and it is perhaps easiest to begin to demonstrate their relation in a situational context.

The specificity of the physician's approach and the abstraction of the humanist's approach can come together in clear complement when the two are directed toward the same issue, such as the particular ill-

ness and circumstances of a particular patient. While medical students are learning to develop a habit of examining the human as well as the medical aspects of a patient's situation, they can be assisted by repeated demonstrations of the humanistic mind working with the medical mind to solve or at least illuminate real (rather than hypothetical) problems.

Because undergraduate education takes place away from the patient-centered, action-oriented atmosphere of the teaching hospital, humanities studies cannot be offered in a context that is meaningful and memorable to the premedical student during his undergraduate years. The atypical student who enters medical school with a background in the humanities is seldom able to perceive for himself how his non-scientific preparation can serve him in the vastly different milieu of medical school, and so independent carry-over tends to be slight.

The relation between immediate payoff and remembered learning was illustrated by an example from the liberal arts offered by Noel Perrin, who cited the well-known futility of sending students off to learn how to "use" the library, without giving them a library project that provides context for the experience. Knowing the location of the Rare Book Room does not seem to be significant information when one has no wish to read or even look at a rare book.

6. Several suggestions for future research emerged from the discussions. All aimed at acquiring data (rather than impressions) about the long-range behavioral and attitudinal consequences of educating physicians in both the humanities and medicine.

Students with dual backgrounds

Max Black proposed selecting 100 students who would first receive a thorough liberal arts education and then enter medical

school. Among developments he would observe would be the point at which each student made a serious commitment to medicine; his reasons for doing so; and his subsequent "use" of his humanities background. Would he draw upon it appropriately for both personal enrichment and professional application, or would he reject it as irrelevant to the pursuit of competence in medicine? What kinds of books and journals would he be reading ten years after the completion of his formal studies? What kind of attitudes toward patients would he develop, and how would he relate to his colleagues, friends, and acquaintances? In short, would the deliberate pursuit of a dual background actually produce a humanist-physician?

Practitioners with dual backgrounds

Listening to the above proposal, Sam Martin recalled a number of practicing physicians within his acquaintance whose education included formal study of the humanities as well as medicine. Would it be pertinent, he wondered, to examine their subsequent professional careers and personal development? Are there noticeable and desirable differences between these physicians and their peers who elected the traditional premedical major as preparation for medical school? What directions did these more broadly trained individuals seek when they became practitioners? Are they indeed practicing medicine or doing something else? If the latter, why? What alternative was chosen--and again, why?

On-going M.D./Ph.D. programs

As Lynn White pointed out, programs of combined study leading to both the M.D. and Ph.D. degrees have been in existence

for some time. An evaluation of these might indicate what can be expected from non-standard ways of offering training in medicine. Does the opportunity to pursue a Ph.D. while studying medicine result in a more broadly trained physician, or in a more specialized scientist?

The graduates of on-going combined degree programs perhaps are not the ideal that this conference sought to define, but the programs themselves may contain a structure that can be adapted to supply at least some of the faculty that will be needed if medical schools are to take up seriously the task of offering humanities studies to medical students.

In any event the experience already accumulated within M.D./Ph.D. programs should be examined for whatever value it may have to those who wish to change medical education so that it will include more than the study of medicine, arranged and presented in traditional patterns.

Changed admissions policies

Many medical schools have changed their admissions policies in significant ways, especially by easing requirements for specific kinds and amounts of premedical study in the basic sciences. The old "premed" major is less insisted upon now as a requirement of admission; indeed, some schools openly welcome liberal arts majors, and deliberately seek a variety of undergraduate backgrounds for each year's entering class.

This official change in admissions policies is concurrent with changes in the self-selection process that occurs among students who apply to medical school. When the clinicians and teachers at today's schools speak of the "new breed" of medical student, they are reacting

to the fact that today's medical students are indeed different from yesterday's. Their reasons for choosing to study medicine are different, and so are their attitudes toward the experience of medical education and its ultimate application.

Administrative change together with student change are altering the educational climate of medical school. The extent and meaning of this change should be studied seriously, because they have ramifications for humanities programs in medical schools. It is just as necessary to the humanist in the medical school as to the clinician in the teaching hospital that his respective teaching be keyed to today's medical student, not yesterday's.

Concluding Address

REFLECTIONS, REFRACTIONS, AND PROSPECTIVES

Edmund D. Pellegrino, M.D.
Dean of the School of Medicine
Vice President for the Health Sciences
Director of the Health Sciences Center
State University of New York at Stony Brook

REFLECTIONS, REFRACTIONS, AND PROSPECTIVES

The task of the conference summarist is always unenviable. His options are limited: He can remain faithful to every insight and bon mot and turn in a compendious report--complete, precise, and lifeless. Or he can more boldly select those facets which best fit the topography of the issues as they appear to his own mind. The latter course will displease some, disappoint others, and inevitably reveal the summarist's own biases.

With full apologies for its inherent defects, I shall undertake the latter course. If the physiognomy of the discussion as I shall comment upon it seems unfamiliar, you may attribute it to the high refractive index of my own mind and not the erratic nature of the discourse. Happily, the tapes and the prepared speeches will be available to redress any serious aberrations produced by the faulty lenses of my intellect.

Clearly, we have experienced in the past several days the first stages of an intercultural exchange in which differences in language, values, and life styles were exhibited. Our participants share in common a university education, it is true. The physicians have had some exposure to humanist studies, even imbibing them to some degree. The humanists have devoted their lives to these studies and to their explication. But we still have much to learn of the differences in meaning of the terms "humanities" and "medicine" to each of us. Indeed, our discussion prefigures what must occur on the larger scene between humanists and physicians if fuller advantage is to be taken of the insights into man developed by each of us. Our hopes for the humanist education of physicians and for a more humane management of individual and social

ills rests on the continuation of this intercultural dialogue on our campuses and elsewhere.

In addition to the manifest difficulties in definition of common terms essential for the discourse, there was considerable wariness of too deep an operational interpenetration of the humanities with medicine. As a consequence, the mutual benefits of closer associations were developed only sketchily. I propose to summarize the state of these problems at the interface, and then suggest what may be done concretely to overcome them at the operational level.

1. Problems of Definition and Language

Recurrent difficulty was experienced in defining precisely what it is we were talking about. Among both the humanists and the physicians, there was almost a polymorphic use of the terms "humanism," "humanitarianism," and "humanities." Despite a number of attempts at careful definition, no unanimity was achieved in any of the discussion groups. While this is not an unexpected problem, it complicates even the first steps at fruitful exchanges between humanists and medical people.

Some of the varied usages and interpretations of the term "humanism" as applied in medicine are worth examining.

For some, humanism is a rather vague symbol useful for referring to the sum total of defects, dissatisfactions, and discontent with medical education experienced by educated people in other disciplines. It expresses a certain antipathy to the presumed technical and vocational education which, in the opinion of educated people outside of medicine, so many physicians seem to posses.

For others, the term "humanism in medicine" has become the symbol for new sources of inspiration and inducing changes that will give fresh

meaning to medicine and to life. Humanism in this sense somehow refers to bringing medicine and other intellectual disciplines into closer conformity with the concrete and existential experiences of modern-day man. It is a symbol also of concern for the person who is endangered by modern society, technology, and medicine, which tend to overshadow man.

Still another view equates humanism with a sort of utopian aspiration for a new society that will, in ways not defined, be more humane, more attuned to man and his intuitive aspirations for the good life. This utopian view symbolizes on a grand scale a disaffection with human society and existence, and questions its quality and its very purposes.

Humanism is used by still others to be equivalent to the medieval Trivia in modern dress. Grammar, rhetoric, and logic are translated as Communication, Continuity, and Criticism. These three attitudes of mind and human skills are considered essential for the genuine physician who wishes to be humanely educated. This is not far from the view Scott Buchanan put forth so cogently in his Doctrine of Signatures.[1]

An additional recurrent theme was the concept of humanism as equivalent to an education based in the ancient languages and classical studies, but modernized by the addition of social, political, and scientific elements. This is not too different from the post-Renaissance view making humanism a mode or a system of education.

Underlying each of the definitions and often intermingled with them was the frequent equating of humanism with a compassionate, considerate, understanding, or sympathetic approach to other human beings and particularly, of course, to patients. Indeed, at times it would appear that humanism was confused with humanitarianism. There was the repetitive

[1]Scott Buchanan, The Doctrine of Signatures. London: Kegan, Paul, 1938.

notion--or perhaps it was a hope--that a deeper study and appreciation of the humanities by medical students and physicians would make them more responsive to the personal and psycho-social dimensions of their patients' problems.

Clearly, one of the first issues to be addressed in any fruitful dialogue between humanists and medical people is finding a suitable operational definition of the term "humanism." It is unlikely, without pretension and the certainty of failure, that an educational program could attempt to inculcate all the attitudes or satisfy all the deficiencies implied in the spectrum of definitions used in this conference. Underlying these variant definitions there appears to be a common thread which might constitute an operational definition of humanism for the contemporary physician, a definition quite different from the one suitable for his Renaissance or Victorian counterpart.

The distinguishing feature for a modern-day humanism appropriate to medicine might well be its focus on human values: understanding and appreciating the values of individual persons and of human society, learning to respect the values of the patient in every medical transaction, and directing the technical and organizational panoply of modern medicine to human and humane purposes. For modern man--and the modern physician--the orientation is more pertinent than a humanism based in a familiarity with the ancient languages and classics or in literary and rhetorical skills or a knowledge of languages and literature. These latter are not to be demeaned, and the physician who combines them with a sensitivity to human values is unique indeed. But it is the primary emphasis on human value which is essential if medicine is to avoid being swallowed by its own technology or dehumanized by its complex organization.

Manifestly, a physician who understands the human dimensions of his practice will have a higher probability of consciously respecting the person of his patient. This may not be the same as compassionate care and humanitarianism, but it can move the physician further along this road. True compassion is more a matter of character and emotional development than of education. All may not possess this degree of sensitivity to another's suffering, but an education that encompasses a concern for human values should forestall the more obvious violations of human dignity which too frequently mar medical practice today.

2. Some Cross-Cultural Impediments

The problem of definition was more than surpassed by the exhibition of a set of attitudinal barriers that must be circumvented before humanists and medical educators can work cooperatively, each contributing to the intellectual growth of the other.

To begin with, most humanists and physicians really do not know much about each other, and have very little opportunity for formal contacts in the course of their professional or social lives. Sharp differences in experiences and life styles were experienced in a certain mutual wariness arising out of a series of unexamined assumptions--a veritable academic xenophobia.

The physician was too easily prone to take one or two rather extreme positions with respect to the humanities. At one extreme he had an excessive regard for the humanist's capacity to solve the value questions in medicine and to make educated men of physicians by mere exposure to the humanities. On the other extreme the physician could not at all see what the humanities could contribute to the daily practice of medicine. This vacillation between extremes of overgenerous adulation and over-

critical patronization has frustrated the early stages of the discussion.

Humanists, on their part, were wary of too close an approach to medicine, and experienced insecurity when dealing with physicians, especially in the clinical setting. Those who participated in medical school education confessed to being over-awed by the urgent demands for prompt decision-making on important issues. The undeniable primacy of the physician in emergency situations tended to be translated to the more ordinary teaching encounters. This understandably induced some reluctance on the part of humanists to penetrate too deeply into clinical territory. Some of the humanists, on their part, exhibited an over-acceptance of medical formulations, even in areas where they could afford, as educated and intelligent people, to be critical and to ask fundamental questions. A desire to be useful and to be wanted, coupled with the humanist's insecurity in the clinical context, seems to have compromised his true usefulness in the medical setting.

Differences in educational experiences contribute further to the difficulties in intellectual exchange. Very few humanists have had any genuine contact with laboratory or experimental science. Physicians have of necessity had considerable training and exposure to these fields. Physicians tended to overemphasize the values of experimental science, even though they might use very few of these elements in their own daily work. The "two cultures" dichotomy generated an even greater degree of xenophobia.

Disconcerting also was the variation in the urgency of the daily issues dealt with by both groups. The rapidly evolving state of medicine and its emergence as the major instrument of the new biology, force it to make value decisions well before they have received full cogitation.

The humanist can approach these questions in a more leisurely, abstract, and theoretical way. He is without the uncomfortable requirement of making daily decisions without all the needed data or the requisite theoretical substrata.

There are additional problems in being a humanist in a medical school. One is to acquire the stigma of the applied disciplines by too close association with what many university faculties regard as vocational or technical disciplines. To teach in a professional school--even if it is one's own subject--is to be relegated to a service role or even to become a Greek slave.

Then, there is the isolation from one's colleagues in the parent discipline and the real temptation to lose one's identity in that discipline--a true man without a country, unaccepted by either medicine or one's old friends. The possibility even exists that the humanist's research may be directed to experimental problems and questions somehow regarded as less rigorous and less pure than the humanist's usual fare.

All of these dangers require hardy and secure, well-established souls willing to run the risk of slowing or stopping the advance up the academic ladder. These are somewhat facetiously described matters, but they are also of the greatest importance in obstructing the free exchange between humane and medical disciplines so earnestly sought by so many today.

These impediments need not invalidate the attempt at dialogue, but they must be clearly recognized and specifically dealt with. Some "protection" should be afforded the humanist who ventures into the medical setting. He should be assured of an appointment in his primary discipline; he should not be alone, but be a member of a group of human-

ists sufficient in size to constitute a critical "mass" and allow for intellectual stimulation within itself. The physician can assist in breaking down these barriers by more deliberate efforts to reduce the anxieties of non-physicians in a clinical setting. He can encourage criticism, comment, and participation; he can more frequently explain the technical bases for his decisions.

If there is to be a greater participation on the part of the humanities in medical education, cross-cultural barriers must be understood and circumvented. Too many humanists and physicians give up at the first encounter, and become discouraged by the differences in language, style, and behavior. Persistence and patience in the dialogue will carry it through to new levels of understanding. This, in fact, began to occur as the conference progressed.

3. Mutual Benefits to be Gained: Medicine and the Humanities

The initial stage of the discussion tended to focus around the issue of what the humanities can contribute to medical education. Medical educators asked the question in a somewhat challenging way: "Show me what you can do," they seemed to say. They were genuine in their seeking for help, but skeptical of what the humanities could do. Some humanists responded by trying to emphasize the utility of their disciplines to the physician. Later in the conference, the mutual benefits of the association were emphasized, and the pressure on the humanists to "prove themselves" was sensibly lessened. It became clear that both medicine and the humanities stood to gain from closer association.

Some of the advantages for medicine would appear to be as follows:

In any dialogue with the humanities, medicine accrues the advantage

of becoming a more fully examined profession. Opportunities are provided for critical inquiry into the uses of medicine for the individual and for society. In addition, the discipline of medicine itself, its philosophical assumptions, mode of reasoning, and epistemic basis, as well as its historical and intellectual development, can be clarified by the tools the humanists bring to such a study. As a consequence, medicine can acquire a deeper perception of its own nature. Its students, teachers, and practitioners will gain deeper insight into their own values and purposes as professionals. In addition, student and faculty in contact with the humanities can imbibe some of the attitudes of mind and modes of thinking of these disciplines. For the past fifty years the physician has had a modestly good scientific education, the principles of which he uses, at least to some degree, in his practice. He has been, however, innocent of any formal use of his education in humanities. The physician needs to develop a sense of human values as they pertain to his ordinary and professional life. He needs to understand something of the intellectual techniques, the modes of reasoning, and the rules of evidence used by philosophers and historians. These modes share some things in common with the sciences, but they are also different. It is these differences that need to be better understood.

Hopefully, as a consequence of this exposure, some physicians will be impelled to undertake an in-depth study of one of the humanities and devote their professional and research activities to the exploration of questions at the interface between medicine and philosophy. A very fine precedent can be found in the significant number of clinicians who have taken advanced study and research in the basic laboratory sciences and have brought these to the bedside. Similar immersion by medical people

In the social sciences and humanities would open up areas of investigation in what might be called the "clinical context" of philosophy and the humanities.

For the majority of medical students and physicians, a closer contact with the humanities and the social sciences should help to make them more understanding of the value systems of their patients, of the importance of cultural and historical factors in the response to illness and in the acceptance or rejection of therapy. A study of the humanities cannot be expected to make a physician humane and compassionate. But it can do something to counter the overwhelming thrust toward the dehumanization in our medical care systems and the consequent alienation of patients from that system.

Some of the major problems now facing medicine and society are in the realm of what may be termed social ethics. Traditional medical ethics has been individual- and person-oriented. Its classic expression in the Hippocratic Corpus consists almost entirely in the responsibilities of individual physicians to individual patients. In the last half-century, it has become obvious that many of the more important medical issues transcend individual transactions, and that no physician can ignore the social consequences of his individual medical acts. We need today to develop an expanded and refurbished ethics of medicine equal to the new questions raised by recent medical progress. The development of such a new and expanded ethics is greatly enhanced by a deeper contact with colleagues in the humanities and social sciences. This may turn out to be the major benefit to be obtained by the exchange.

Last, acceleration of the medical curricula makes it almost mandatory that much of the liberal and general education of the physician take

place in the course of his professional education. Many fertile possibilities for teaching humanities and human values exist in the concrete, specific, and clinical matters of a medical education. Properly utilized, a medical education can become a humanizing experience for the student and the faculty.

Teaching the humanities in the context of a medical education will provide a more lasting impression for the medical student than the present practice permits. Teaching art, literature, and philosophy, for example, as isolated phenomena or (as, unfortunately, they are too often seen) necessary obstacles to entry into medical school puts the humanities at an unnecessary disadvantage with this group of students. The relevance question can hardly arise if the humanities are concretized by permitting their discussion to arise out of the human situations which are the basis of a medical education.

There is little question that the personal growth of the physician as student is tied to his capacity to expand his own range of satisfaction--the antidote to the boredom of routine even when he is an able craftsman--is greatly enhanced by a serious pursuit of one of the humane studies throughout the life of the physician. This is far more securely based if the humanities are warp and woof of a medical education and not mere prolegomena, hastily to be put aside for the real matter of a medical education. The physician's capacity to satisfy the multiple needs of his patients is surely related to the degree that he is himself a more complete human being.

There are equal, but perhaps less well-recognized, advantages to the humanities by a closer concourse with the medical disciplines and the clinical setting.

To begin with, the humanities can gain by the exposure of their assumptions and theses to the concrete-minded attitudes one finds in the clinical setting. Thus, the humanities, like medicine, can become an "examined" discipline benefitting from the fresh points of view and, indeed, the challenges they will encounter in dialogue with medical faculty and students. An increasing number of humanists are aware of the need to make their studies relevant to the concrete and pressing problems of contemporary existence. Deeper involvement with medicine and the other health professions provides a rich phenomenological base for the humanist's cogitations and formulations. Indeed, there are in this contact real possibilities for a close approximation of theory and practice, as yet rare in the history of western culture.

A very distinct and yet-to-be-utilized advantage of a closer association with medicine lies in the use of the health sciences center as a research resource for humanists and social scientists. The university hospital, its clinics, neighborhood extensions, and ambulant facilities provide settings for the study of phenomena of interest to the social scientist and the humanist. For the theologian, there are the existential and theological problems of illness, incurable disease, and the dying patient. Here, the lawyer and philosopher can study at first hand the process of evaluation and surveillance of human experimentation, value systems of students, faculty, patients, and the community. These immediate and concrete opportunities are nowhere explicitly provided. In short, the health sciences centers provide entry into a phenomenological cornucopia of concrete, immediate, real, personal, changing human experiences. These phenomena will help the humanist to ground his cogitations in the "real life" situations he is so often accused of forgetting.

Perhaps equally helpful is the exposure of humanists to the mode of teaching employed by clinical academicians. This mode is rooted in the concrete case--a case "worked up" by the student himself. The development of ideas is from this concrete "case" and detailed to the abstract and general. There is little question of "relevance," since the student is "involved" with his own case and the discussion starts with his case. Students nowadays often complain of the abstractness of liberal studies. Because of the preference these days for images rather than ideas, they miss the utility and the "relevance" of the humanities. By learning more about the case method, the humanist can adapt it to his own needs and capitalize on a mode of teaching and hearing which has a long tradition behind it.

Finally, there is growing interest in the idea that medicine can be taught as a liberal study in the undergraduate years. The newer knowledge of medicine and its growing perceptions of the totality of human biology in health and illness has not yet been exploited this way in universities. If the proper study of man is man, then should we not give serious thought to the design of an undergraduate educational program built on an expanded conception of human biology? This conception includes the physical and anatomical constitution of man, as well as his social and emotional behavior and intellectual modes of existence. This may well be the basis for contemporary liberal education for today's bewildering world, in which the nature and purposes of human existence are so much a puzzle to old and young alike.

In such a study, medicine, the humanities, and the social sciences could all learn as they enable the student to see the folly of a fragmented conception of man's totality. This program could not succeed

without the further extension of the intimate and continuing exchange between medicine and the humanities envisioned in this conference. An exchange would then continue without interruption through the course of professional and continuing education.

The conference discussion repeatedly fortified the view that the humanities, as well as the medical sciences, have much to gain by closer dialogue. What is puzzling is why this dialogue is not further along than it has been and why such wariness as does exist has not been dismissed. Sometimes, the best way to deal with a new or threatening situation is to engage it directly. We are probably at that precise point so far as the relationships of humanities and medicine are concerned. What concrete steps can be taken even now to open up the dialogue more fully, to integrate humanities into the fabric of medical education, and to open up mutual opportunities for joint study in depth of each other's phenomena as a source of mutual inspiration?

4. Next Steps

The purposes of this conference have been in considerable measure achieved: issues have been defined, needs identified, obstacles delineated, and mutual benefits enumerated. The next conference will have a somewhat different composition: i.e., a predominance of medical educators and a smaller number of humanists--some drawn from the participants of this conference for the sake of continuity, and some from those who have not participated. The second conference will concentrate on specific measures that can be used to introduce the teaching of the humanities into the fabric of medical education. But even in this first conference there was recognition of several basic requirements which would probably characterize any effective program. These conditions or requirements

were derived from the experiences of those who had actually participated in teaching humanities in medical settings. There were on these points rather general agreement:

(a) First, there must be a "critical mass" of humanists in any endeavor to teach humanities in the health sciences. This derives from a need to retain identity with the parent discipline; from a need for the discourse with others in one's own field so essential to "keeping up" and to generating new ideas; and, finally, from a need to protect the humanities against being overshadowed by the medical subculture and the urgent requirements of the clinical setting. Joint appointments in departments of humanities whenever possible might supply and satisfy some of these needs, but not entirely. It would assure academic advancement in the parent discipline--a matter of personal significance to those who teach in the medical setting.

(b) The necessity for teaching in the actual clinical setting, with concrete and individual situations encountered by students, was affirmed. All participants agreed that standard lectures in "principles" of humanities or social sciences had been quite ineffective. But philosophy, theology, ethics, history, etc. could be taught readily in clinical situations. Such teaching is probably best conducted in seminar fashion built around specific topics illustrated by the case in question. Readings also should be designed around the exigencies of the cases and the subject to be explored, rather than the standard texts used in humanities courses.

(c) Several levels of study were recognized. The first level would be for all students, directed to introducing them to the ways of thinking and intellectual tools and values of the humanities. Some elements of logic and rhetoric could, for example, be included in the analysis of the student's presentation of the case, its history and analysis. A second level--for those who wish more depth in specific fields--could be offered as electives and consist of seminars, readings, and research in particular subjects of special interest to medical students, in which the approaches of the humanist would be vital. Last, those students who wished to study the medical humanities in greater depth could spend a full year or two, or go on to graduate work for an advanced degree in one of the humanities, with thesis work directed to some problem in the expanding zone of concern between medicine and one of the humanistic disciplines. Out of this latter group, we might eventually expect to see a new group of faculty members emerge who would themselves teach the medical humanities in health sciences centers at all levels.

(d) There was about equal emphasis placed by the participants on the importance of teaching the content of the humanities on

the one hand, and their methodology and intellectual processes on the other. No one favored content or method exclusively, but there was considerable variation in the importance attributed to each.

These matters of how best to introduce the humanities operationally in medical education will come under further scrutiny in the second conference. That conference is designed to take the issues defined in this first conference and carry them further into program design, feasibility, and methodology. The work of the last several days will provide the basis for this further discussion, and will be made available to the participants in the second conference well before the meeting date.

I hope these selective comments will not have skewed the actual discussion that took place, or imposed a conceptual structure that was not present. This is the way the conference looked to your summarist, and how it squared against the matrix of his own thoughts.

I would like to leave you with the thought with which the poet St.-John Perse closed his Nobel lecture:

> "In these days of nuclear energy, can the earthenware lamp of the poet still suffice? Yes, if its clay remind us of our own. And it is enough for the poet to be the guilty conscience of his time."[2]

Is it too much to expect that we must each be the guilty conscience of the other so that our respective disciplines can be made to serve humane ends and not their own? This is justification for this institute and for its continuation into the next.

[2] St.-John Perse, Collected Poems. Princeton: Bollingen Series, LXXXVII, 1971.

PARTICIPANTS IN THE

INSTITUTE ON HUMAN VALUES IN MEDICINE

First Session
April 12-14, 1971

Arden House
Harriman, New York

Thomas J. J. Altizer, Ph.D.
Professor of English
State University of New York
Stony Brook

Professor Samuel A. Banks
Assistant Professor of Medicine
and Religion
Department of Community Health
University of Florida
Gainesville

Max Black, Ph.D.
Department of Philosophy
Cornell University.
Ithaca

Roger J. Bulger, M.D.
Professor
Department of Community Health Sciences
Associate Director of Medical Education
Duke University Medical Center
Durham

James Carmody, Ph.D.
Special Assistant for Ethical Issues
in Health Services
National Center for Health Services,
Research and Development
Rockville

K. Danner Clouser, Ph.D.
Associate Professor of Humanities
The Milton S. Hershey Medical Center
The Pennsylvania State University
Hershey

Leighton E. Cluff, M.D.
Professor and Chairman
Department of Medicine
University of Florida
Gainesville

Robert Graham, M.D.
Assistant Administrator
for Agency Goals
Health Services and Mental Health
Administration
Rockville

Charles K. Hofling, M.D.
Professor of Psychiatry
St. Louis University
St. Louis

Lorraine L. Hunt, Ph.D.
Project Director
Institute on Human Values in Medicine
Baltimore

Louis Lasagna, M.D.
Professor of Pharmacology
and Toxicology
University of Rochester
School of Medicine and Dentistry
Rochester

Samuel P. Martin, M.D.
Department of Social and
Preventive Medicine
Harvard Medical School
Boston

Ronald W. McNeur, Ph.D.
Executive Director
Society for Health and Human Values
Philadelphia

David F. Musto, M.D.
Assistant Professor of History
and Psychiatry
Yale University
New Haven

Michael Novak, Ph.D.
Associate Professor of Philosophy
and Theology
State University of New York
Old Westbury

Father Walter J. Ong, S.J.
Professor of English
Professor of Humanities in Psychiatry
School of Medicine
St. Louis University
St. Louis

Edmund D. Pellegrino, M.D.
Vice President for Health Sciences
Director of the Center
State University of New York
Stony Brook

Mr. Noel Perrin
Professor of English
Dartmouth College
Hanover

Carroll Smith Rosenberg, Ph.D.
Assistant Professor
Departments of History and Psychiatry
University of Pennsylvania
Philadelphia

Donald W. Shriver, Ph.D.
Associate Professor of Religion
Director, University Program on
Science and Society
North Carolina State University
Raleigh

Charles R. Stinnette, Jr., Ph.D.
Professor of Pastoral Theology
and Psychiatry
University of Chicago
Chicago

E. Fuller Torrey, M.D.
Special Assistant to the Director
National Institute of Mental Health
Rockville

Bernard Towers, M.B., Ch.B.
Professor of Pediatrics and Anatomy
Center for the Health Sciences
University of California
Los Angeles

Joseph P. Tupin, M.D.
Associate Professor and
Vice Chairman
Department of Psychiatry
University of California
School of Medicine
Davis

Professor Ruel W. Tyson, Jr.
Assistant Professor of Religion
University of North Carolina
Chapel Hill

Professor E. A. Vastyan, B.D.
Associate Professor and Chairman
Department of Humanities
The Milton S. Hershey Medical Center
College of Medicine
The Pennsylvania State University
Hershey

Lynn White, Jr., Ph.D.
Professor of History
University of California
Los Angeles

George A. Wolf, Jr., M.D.
Professor of Medicine
College of Medicine
University of Vermont
Burlington

ADDENDUM

Excerpts from "A Survey of the Current Status of Humanities Programs in Medical Education," a final report submitted to the National Endowment for the Humanities in February, 1970, at the conclusion of Grant No. H 69-0-187.

Sponsor: Association of American Medical Colleges

Project Director: Lorraine L. Hunt, Ph.D.

Excerpts from "A Survey of the Current Status of Humanities Programs in Medical Education"

A variety of difficulties complicate the task of presenting humanities studies to individuals whose major commitment is to medicine. The organization of traditional medical education and practice, and the organization of the work of the traditional humanist are often quite distant from each other, and this distance causes a number of problems. Since clarification of some of these problems should contribute to their solution, it might be helpful to look at three categories of difficulties involving medical students, administrative matters, and the humanist himself.

Medical Students

Medical students tend to be minimally receptive to what they regard as irrelevant to their training. Often they cannot see how material such as the humanist is likely to present can be helpful to them later on in their practice of medicine. Moreover, pressures from "important" courses (such as physiology and biochemistry) often move other material into the background of the medical student's attention, so that even if he is genuinely interested, he may find that he has little time for humanities studies.

The fact that the humanist differs considerably from the medical student's traditional role model also makes it difficult for the humanist to be effective within the medical setting. Because so much of medical education involves an apprenticeship kind of learning, medical students inevitably imitate their model, the physician-teacher. Typically they admire him very much, and shape their expectations of themselves

in terms of their model's person and performance. In so doing they assimilate his attitudes as well as his skills; therefore if their professor of medicine, for example, makes it clear that he regards humanities studies as irrelevant to learning and practicing medicine, most of his students will adopt this point of view and devaluate accordingly any humanities endeavor they may be involved in, whether or not it is "required."

The traditional humanist's status in the eyes of medical students is affected negatively also by the fact that he is not a clinician. He is remote indeed from patient care, and he does not demonstrate the patient-centeredness of the medical faculty. Since the medical world as a whole revolves around doctor-to-patient relationships, the humanist seems all the more irrelevant for having no part in treating patients.* In order to be most effective in the medical setting, the humanist must be able to relate the material he presents directly to the area of patient care.

Administrative Matters

Administrative matters within medical institutions often complicate the productive association of humanists and medical educators. Since the humanist does not engage in clinical services or in the kind of research that is valued and hence rewarded by the medical establishment, he cannot be taken into the medical school organization as if he were just another member of the faculty.

* It is interesting to note how many non-M.D.'s (usually behavioral and social scientists) whose professional education has included special training in counseling and psychotherapy, engage in some degree of "practice." They "see" patients the way an M.D. does, and this quite clearly enhances their position enormously in the estimation not only of medical students but also of the medical faculty.

Since a course or series of lectures in the humanities is usually an unprecedented offering in the medical school, merely arranging it can become frustratingly complicated. Under which departmental aegis will the humanist's course fall? Will it be a required course or an elective? If required, in which year will it be taught? Will it require that the department in which the humanist works give up another course it usually offers in order to make room for a course in the humanities? If so, which one will be eliminated?

Another order of administrative difficulties concerns the familiar issues of salary, rank, promotion, departmental affiliation, etc. Holders of the Ph.D. in the physical, biological, social, and behavioral sciences are well ahead of the humanist in having already negotiated most of these matters within the medical structure. But the pioneer humanist who is the first of his kind to join a medical faculty has little precedent for working out the mechanics of such an appointment. If he is reluctant to make a full-time commitment, he may find that a joint appointment is difficult to arrange, especially if his home department needs him to help it meet existing departmental obligations. Some arrangements which are administratively acceptable prove personally unsatisfactory to the humanist if he finds himself in Matthew Arnold's predicament: "Wandering between two worlds, one dead,/The other powerless to be born."

All of these administrative matters are important, for they influence to a significant degree how comfortable and happy the humanist will feel within the medical setting. And his feelings, in turn, will influence the effectiveness of his performance.

The Humanist

The humanist himself presents many difficulties which must be resolved before he can contribute positively to medical education. Like the physician, the humanist undergoes professionalization during the course of his doctoral study and makes a commitment to the intellectual life as it is usually pursued in the academic environment of schools of liberal arts. In contrast, medical school education, with its pressures for learning techniques and skills which may intervene in life-and-death situations, represents a foreign environment to the humanist.

In addition, he may find that certain supportive elements of his usual work situation which he has come to rely on do not follow him when he ventures into the medical setting. The Ph.D. who is a specialist is much like the M.D. who is a specialist. As a teacher, he prefers students who have serious interest in and adequate preparation for his material and his point of view. The difficulties noted earlier that are involved in presenting humanistic material to medical students may be seriously discouraging to the humanist in his capacity as a teacher.

As a professional, the humanist enjoys and profits from regular association with like-minded colleagues who understand and value him and his work. However, many of his associates within the medical school may seem alien to him. Medicine is not a speculative discipline, and it does not ordinarily attract individuals who are comfortable with the abstractions and tentativeness of humanistic issues. Hence the humanist may truly feel that his physician-colleagues do not understand his point of view; and, even more demoralizing, he may feel that his work is not valued. Lacking at least some ego-supporting responses now and then from either students or colleagues, he may well find his situation so uncom-

fortable and unrewarding that he will retreat, often with some bitterness and resentment.

In such a situation it is easy for the humanist to intensify the anomaly of his position by asking less of his assigned medical students than their other teachers do. They require and insist; he suggests and recommends. They assign a text; he prepares a list of optional readings. And what is perhaps most costly to the humanist--and ultimately further damaging to his status--is that he tends to feel that he lacks the "right" to press the students all the way to full engagement with the issues that are at the core of what he has to offer them. Thus he may see himself as dealing in a diluted commodity, and he may feel embarrassed and guilty about what he regards as not an adaptation of his discipline to special circumstances, but a compromise of professional integrity.

Obviously, these circumstances indicate that the role of the humanities in medical education at the present time is a difficult one. In order to move from the present situation to one in which the humanities have a full and meaningful place in the education of physicians, dialogue between humanists and other professionals involved in medical education must move forward significantly. The issues presented above and others not yet elucidated must be explored in an open and honest manner. Above all there must be clarification of goals on both sides.